



St. Francis Dental Care

Family Dentistry

FINANCIAL OPTIONS

Welcome to St. Francis Dental Care! We are committed to provide you with the best possible care, and are pleased to discuss any of our professional fees with you at any time.

Full payment is due at the time of service for your dental treatment. For your convenience we accept Visa, MasterCard, Discover and Care Credit.

We offer the following options for our self-pay patients:

- a. 10% senior courtesy for patients 60 and older when paying with cash/check.
- b. 10% courtesy for self-pay patients who pay their treatment plan in full, with cash/check before they schedule an appointment.
- c. 5% courtesy for those who pay in full with cash/check the day of scheduled appointment.
(Only one courtesy may apply for any given patient or procedure.)
- d. Interest free financing through CareCredit
- e. Automatic credit card withdrawal

INSURANCE

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

- If you are insured, we will submit insurance for you. It is your responsibility as the insurance carrier, to provide the dental clinic with correct and complete insurance information. **Your portion due for your dental investment will be due at time of service.**
- Any adult that accompanies a minor child and is the parent (or legal guardian) is responsible for full payment for that minor child at the time of service.

If collection action becomes necessary, I understand that I will be liable for collection agency fees (35% of balance) and/or attorney fees (45% of balance). **In consideration of services provided to me, my minor children, I/we agree to pay charges not covered by insurance.** Thank you for understanding our financial options. Please let us know if you have any questions or concerns. A copy of our financial options is available upon your request.

RESPONSIBLE PARTY

SIGNATURE _____ DATE _____

DATE _____

(Parent or Guardian must sign if patient is a minor)

I, _____ authorize St. Francis Dental Care, PA to apply any co-payment to my credit card Visa/Master/Discover/CareCredit on behalf of myself and family. **REQUIRED IF TREATMENT IS RENDERED WITHOUT PARENT PRESENT.**

EXP _____

SIGNATURE _____ DATE _____