

The following financial arrangements are available:

o **OPTION A** **PAYMENT IN FULL AT TIME OF SERVICE**

- 1. Payment is expected at the time of treatment by cash, check, Visa, MasterCard, American Express, Discover Card, Care Credit, or Citi Financial.

o **OPTION B** **COVERAGE BY DENTAL OR MEDICAL INSURANCE**

- 1. Fees for consultation and necessary x-rays are payable in full at the time of service.
- 2. If we are able to predetermine insurance coverage electronically, you may know your total financial responsibility prior to surgery. If not, 50 percent of the total surgery/anesthesia fee is required prior to treatment. After your insurance has paid, you will receive a final bill showing your remaining balance. The balance will be considered payable in full at that time. Option C (below) is available to pay such balances. Unpaid account balances after 60 days will be charged monthly interest at the rate of 1.5% (18% APR).

o **OPTION C** **FINANCING TREATMENT FEES OR BALANCES**

Patients wishing to finance treatment fees may be eligible for commercial financing. Please request details from our Finance Manager. We offer special financing through Care Credit and/or Citi Financial. (*If your application is NOT approved you must be prepared to pay your balance in full at that time.)

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collections costs, attorney fees that we incur, plus all court costs. In case of a lawsuit, you agree the venue shall be in Nicholas, Raleigh, or Mercer County, from whichever office the service was provided and fee was billed.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service, plus any previous outstanding balances.

Returned Checks: There is a fee (currently fifty (\$50) dollars) for any checks returned by the bank or Telecheck for insufficient funds.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, or if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at one of our offices may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility not our office personnel's duty to collect from the other parent.

I do understand that the fees quoted and my deposit are just an estimate, not a guarantee of benefits, and I may have a balance after my insurance pays and I confirm this with my signature below.

Regardless of the amount of insurance reimbursement, **ALL UNPAID BALANCES ARE DUE 60 DAYS FROM THE DAY OF SURGERY.**

I agree to the financial plan outlined above and will be responsible for payment of all fees for treatment.

Signature of Guarantor	Printed Name	Date
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Witness' Signature	Printed Name	Date
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