Belvidere Dental
FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology. **Please understand that payment of your bill at time of service** is considered part of your treatment. The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any treatment.

Methods of Payment

1. We require payment in full by cash, check, or credit card (MasterCard, Visa, and Discover).
2. Care Credit, Lending Club for dental procedures with affordable monthly payment plans.

As a courtesy to you, we will file your claim and accept assignment of benefits if you have signed the direct payment authorization form. **We request that your estimated co-payment and deductible be paid at the time of service.**
It is the patient's responsibility to pay any remaining amount that is not covered or denied by your insurance company.

If you are unable to keep your commitment for an appointment, we request at least a 24 hour notification or $75.00 Missed Appointment Fee will be applied to your account. Please understand that when you schedule an appointment time with us, we have reserved this time just to see you.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed with a Collection Agency, for collection or any subsequent legal action, to pay an additional collection fee of 35% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

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Patient Signature (Parent if minor) Date