PURE DENTAL STUDIO

WWW.PUREDENTALSTUDIO.COM

FINANCIAL RESPONSIBILITY STATEMENT

Patient Name _____

Responsible Party _____

Relationship to Patient _____

Financial Policy:

1) Payment in full is expected at the time of treatment.

2) Patients with dental insurance are expected to pay their estimated co-pay at the time of treatment.

3) VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS and CASH are accepted.

4) Long term financing is available through CARE CREDIT (Synchrony) and Lending Club, upon completion of a credit application and approval.

5) Balance over 90 days old are charged an 18% APR service charge monthly.

6) WE reserve the right to charge for appointments cancelled or not kept without 24 hours' notice. The fee is $50.00 per appointment, Saturdays and lengthy appointments are higher.

To Our Patients with Dental Benefits:

Dental Plan Name _____ Group # _____

It is our pleasure to help you file your insurance claims forms or take assignment on your dental benefits as designed by the dental plan indicated above. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines that you are not eligible at the time of service, or makes a determination that you are eligible for reduced level of coverage, by signing this agreement, you do hereby agree to financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

_____ _____

Signature of Responsible Party Date

832.604.7737

PUREDENTALSTUDIO1@GMAIL.COM

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