Advanced Smiles Financial Policy

Thank you for choosing *Advanced Smiles, LLC* for your dental needs. We are committed to providing you, our patient with exceptional state of the art dental care based on your individual needs. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fee and patients' financial capabilities. Please read the following information and sign.

Payment

Payment is due at the time of service unless prior financial arrangements are made. We accept Cash, Check, Visa, Master Card, Discover and Care Credit. Payment for services for treatment of minors is the responsibility of the adult accompanying that minor.

Insurance

Our office is committed to helping our patients maximize their benefits. Insurance policies vary greatly; every effort is made to accurately estimate your coverage but we cannot guarantee coverage due to the complexities of insurance contracts. **Dental insurance is a contract between the insurance company and the patient, not the dentist. Patients are responsible for all cost not paid by their insurance.** If you have any questions, our courteous staff is always available to answer them.

Missed Appointments

We are able to provide the highest quality of care to our patients by assigning each patient a specific time for treatment to be rendered. Please make sure you make your appointment is at a time when you are able to come in.

If you need to reschedule your appointment for any reason, our policy is to charge for missed appointments that are not cancelled at least 48 hours in advance. The charge is $75.00. Please help us serve you better by being on time and keeping your appointments.

Collection Fees

All fees must be paid within 60 days from date of treatment. Any agency fees incurred to collect outstanding balance will be billed to and payable by the account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

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Signature of patient/responsible party Date