Practice Financial Policy

**Accepted forms of payment include: Cash, Check, Visa, MasterCard, American Express, Discover, and CareCredit.

1. Estimated patient portions will be collected at your appointment. Failure to meet these requirements may result in the rescheduling of your appointment.
2. Deductibles and Co-insurance: if your insurance has a deductible that has not been met and/or a percentage that is patient responsibility, this amount is expected at the time services are rendered.
3. Non Covered Charges: Should your insurance company determine a charge to be non-covered, you are responsible for full payment of the said charge.

   We offer short and long term financing through an outside healthcare financing company

(CareCredit). This is the option we make available to those patients needing to make monthly payments. Please let us know if you would like information about this option. Please visit our webpage; www.SorrisoDental.com, to access a link for the financing website.

Returned Check Charge: There is a fee of $20.00 for any checks returned by the bank. _____Initial

ACKNOWLEDGEMENT AND FINANCIAL POLICY:
Please carefully review Sorriso Dental Financial Policy. Once you have reviewed these policies and sign this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Print Patient's Name: _____ Date: _____

Responsible Party Signature:_____ Date: _____

Witness:_____ Date: _____