# SMILEMAKERS DENTAL CENTRE

# FINANCIAL POLICY

The following is a statement of our final policy, we require you to read and sign prior to any treatment. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. It is your responsibility to be aware of your insurance coverage including maximums, exclusions, deductibles, limitations and when any changes are made to your policy, it has become very difficult for us to get information from your company due to the new privacy legislation.

## DENTAL INSURANCE

We accept payment from your dental insurance plan, provided that you have given us complete and accurate information with respect to your coverage. **You are responsible for any balance not covered by your insurance at the time of the treatment.** We accept Visa, MasterCard, Debit, Cash and Cheques. Due to numerous limitations NIHB has placed on dental fee guide payments guidelines we will be billing the patient, parent or guardian for any procedures pr portion of the procedures not covered for any reason by this plan. Payments will be due and payable at the time of dental treatment.

## OVERDUE ACCOUNTS

If the amount due is not paid in full 30 days you will be charged interest to the outstanding amount at a rate of 2% per month, compounded monthly, 26.28% annually. If your account remains unpaid after three months it will be turned over to a collection agency, including interest, plus an additional charge of 100% administration fee to your balance.

## PAYMENT PLANS

With good credit and substantial down payment you can qualify for a 3 month payment plan. The payments will be broken down into three equal payments monthly by post dated credit card.

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**SIGNATURE (person responsible for the account)** **DATE**

**FOR PATIENTS** _____

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## CREDIT CARD AUTHORIZATION

We request your credit card information on file. Any amount under $100.00 will be put through automatically and a receipt will be sent to you by email.

*For amounts over $100.00 please inform us if you prefer*:

☐ **We put through your balance as it is accrued and email you a receipt**

☐ **We call you and leave you a message saying that we will put through your balance the following day. If you prefer to pay by a different method at this time you can call us back and make arrangements accordingly.**

☐ **If you prefer not to leave Credit card you will pay balance in full at the time of dental service.**

**Please note your email address below:**

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## RETURNED PAYMENT

A service charge of $40.00 will be added to your account for returned payments.

## CANCELLED OR MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been reserved especially for you. We require 48 hours notice for appointment changes. **There will be a minimum $50.00 charge for each appointment missed or cancelled appointments**. A missed appointment hurts a waiting patient, our office and yourself. Please ensure the appointment you booked for yourself is at a time that works for your schedule.

_____ _____

**SIGNATURE (person responsible for the account)** **DATE**

**FOR PATIENTS** _____