Financial Policy

Pampered Smiles is proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your healthcare investment, we are providing the following payment options.

INSURANCE

Please be advised that as a courtesy to our patients we will file a claim with your dental plan. However, any and all portions of your dental services that are not covered by your dental plan will be the sole responsibility of the patient.

INITIAL PAYMENT

Our office requires payment in full at the time of treatment.

PAYMENT OPTIONS

1. **Cash (non insurance holders only)**-Prepayment or payment at time of treatment will receive a 5% discount of entire balance of $300 to $500 and a 10% discount on anything over $600 paid in full at time of treatment. ****Does not apply to patients with insurance****
2. **Credit Cards**-We accept all major credit cards as payment for treatment to the extent that your credit limit permits.
3. **CHECKS**-WE ACCEPT CHECKS FOR PAYMENT UPON VERIFICATION. **Starter checks will not be accepted.**
4. **Debit Cards**-We accept all debit cards that have a visa/MasterCard logo.
5. **Care Credit**-a financial loan through their healthcare finance department. Can be used for other healthcare needs where accepted

LABS

Any patient having any treatment done that requires lab work will be required to pay **amount due in FULL** unless prior arrangements have been made with financial department. Pampered Smiles will not be responsible for crowns left in office over 3 weeks. If crown, bridges, etc does not fit after 3 weeks, you will be charged a lab fee for any remakes pertaining to that treatment ranging from $250 to $375 per unit.

MAJOR PROCEDURES

Any major procedures exceeding $1500 will require a non refundable deposit from $500-$1000 NO EXCEPTIONS!

***Please note any balances remaining after 90 days will be sent for further collection efforts and patient is responsible for any attorney fees and collection fess associated with balance owed.**

Patient Signature: _____

Date: _____