Steven P. Ray, D.D.S.

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FINANCIAL & OFFICE POLICY

Thank you for choosing our office for your dental needs. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are available to answer your questions and/or assist you in any way we can. It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. Prior to treatment, you will be advised of the approximate cost. For your convenience, we accept Cash, Check, Visa, MasterCard, American Express & Discover. All emergency dental services or any dental services performed without previous financial arrangements with the office manager must be paid for at the time of services.

This office reserves the right to charge $50 for each missed or cancelled appointments if less than 24 hours' notice is given. After two consecutive missed appointments, it is our policy to not reschedule you for any further appointments. Please be aware that patients may be discharged from our clinic for any reason (non-compliance with doctor's orders, excessive missed appointments, non-payment of bill, etc). If you are discharged as a patient, please be advised that any family members directly related to you and living in the same household (might include, but not limited to: husband, wife, son, daughter, mother, father, etc) will be discharged from our office as well.

ALL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED (IF YOU HAVE DENTAL INSURANCE THIS INCLUDES YOUR ESTIMATED CO-PAY)

We are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental coverage.

The individual insurance relationship constitutes an agreement between the carrier and the patient, not this dental office.

As such, we can make no guarantee of estimated coverage or payment from your insurance company. However, please know that we will do everything possible to see that you receive the full available benefits of your policy

PAYMENT OPTIONS

All patients co-pays and/or fees for services are due prior to, or on the date that services are rendered. ***THERE ARE NO EXCEPTIONS TO THIS POLICY!*** If the estimate our office has provided you is less than the balance owed after insurance pays, please understand that the additional balance is due and is to be paid in full within 30 days of your billing statement.

- Please note that Co-Pay amounts quoted by our staff are only an estimate based on the information that you provide to us regarding your insurance coverage.
- Please remember – You (the patient or responsible party) is responsible for any portion of your dental bill that is un-paid, denied, or pending (for more than 60 days) with your insurance company within 20 days of receiving your statement.
- Please remember that if you apply for an account with CareCredit, though our office can help you with the application process, you are subject to the terms and conditions set forth by CareCredit. Our office takes **NO** responsibility for changes in your payment agreement, changes in your due date, or any additional charges that may or may not be imposed on your CareCredit Account, and has no authority or responsibility to investigate any of the above on your behalf.
- There is also a $25 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or money order.

In consideration for the professional services rendered to me, or at my request, by Steven P. Ray, D.D.S. or his staff, I agree to pay for those services in full. In the event that my account is turned over to a collection agency, I agree that a collection fee of 50% will be added to my account. Additionally, I agree to pay any court costs and attorney fees which may be associated with my account and I agree that venue shall be in Pulaski County, Arkansas. I grant my permission for you to telephone me at work, home or on my cell to discuss matters related to this form.

I have read and understand the above Financial and Office Policy Agreement.

Patient / Guardian Signature: _____ Date:_____