SUMMIT SMILE INNOVATIONS
Innovating Smiles · Elevating Confidence

181 W Wilkes Medical Center Rd
Ferguson, NC 28624
336.973.5060

FINANCIAL POLICY

Payment for services rendered is due at the time of treatment. We accept one or more of the following:

- **Cash, Debit/Credit Card, or Check**
- **Care Credit** - *a healthcare credit card that offers promotional monthly payment plans;* ***subject to credit approval by Synchrony Bank****.*
- **Dental Insurance** - *we accept and file most dental insurances; please note that we are only in-network with Delta Dental, Cigna, and Blue Cross Blue Shield plans. Your policy is a contract between you and your insurance company. We are NOT a party to this contract.* ***We will verify and file your PRIMARY insurance as a courtesy, however, you are responsible for any co-payments, deductibles, or non-covered services****.*

Insurance Notes: Although we may provide an estimate of what your insurance may pay, this is a courtesy and is not a guarantee of payment or eligibility. The insurance company makes the final determination of benefits after services are rendered.

You are responsible for payment of any portion of the charges not covered by your insurance, including deductibles, co-insurance, and services deemed "non-covered" or "not reasonable and necessary" by your plan.

Benefits are payable in accordance with the coverage in effect at the time of treatment is actually rendered and are subject to plan maximums, deductibles, and other limitations. It is your full responsibility to understand the terms and conditions of your coverage. You are responsible for paying any estimated deductibles and co-payments at the time treatment is rendered.

We will gladly file your Medicaid, North Carolina Health Choice, or dental insurance at this office as a courtesy. In order to do so, you must present your current insurance card at each visit. If your insurance fails to pay the estimated amount within 60 days, the balance will become your immediate responsibility.

Returned Checks: Any checks returned by your bank will incur a $30 fee, plus any additional fees charged by the bank. Following a returned check, only cash or credit card payments will be accepted for future services or to settle the remaining balance.

Monthly Statements: If a balance exists on your account, we will send you a monthly statement. Unless alternative payment arrangements have been formally agreed upon, the balance shown on your statement is due and payable in full by the indicated due date. Any balance not paid by the due date will be considered past due.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the balance. If we refer your account to a collection agency, you may be assessed a collection fee to the extent permitted by law.

Cancellation Policy: A 24-hour notice is required to cancel or reschedule. Late cancellations or no-shows may result in the inability to book future appointments.

By signing below, I acknowledge that I have read, understand, and agree to the provisions of this Financial Policy. I agree to pay all charges due (or to become due) to this practice for the patient's care, including co-payments and deductibles.

I understand that I am ultimately responsible for the balance on the account, regardless of insurance coverage. Furthermore, I agree to pay all costs of collecting any money owed, including collection agency fees and attorney fees, if I fail to pay in a timely manner.

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____/_____/_____
(Parent/Guardian if patient is a minor)