

## *Written Financial Agreement*

*Thank you for choosing Politimi Mantzouranis D.D.S. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable to our patients as possible by offering several payment options.*

### *Payment Options:*

- Visa, Mastercard, American Express, Discover, Cash, or Check*
- Convenient Monthly Payment Plans from Care Credit*
  - Allows you to pay over time*
  - No annual fee's and possible deferred interest plans available*

*Our office requires our patient's put a credit card on file for billing convenience and to limit the amount of paper produced for mailed statements. Our office is PCI compliant and your credit card number will remain secure.*

\_\_\_\_\_. *I agree to keep my credit card on file*

\_\_\_\_\_. *I do not agree to keep a credit card on file.*

*-If you choose this option our office will require that you pay 100% of the treatment completed, if you carry insurance a claim will be submitted to your plan and you will be reimburse with in 30days.*

*Dr. Politimi Mantzouranis requires payment prior to or at time of completed treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of the care received.*

*For patients with dental insurance, we are happy to work with your carrier to maximize your benefits. We require that your out of pocket estimated portion of treatment be paid day of the procedure. Your insurance will then be billed directly, and payment will be sent to our office. You, the patient will then be responsible for the difference the insurance does not cover.*

*A fee of \$75 is charged for patients who miss or cancel an appointment without 24-hour notice.*

*Politimi Mantzouranis, D.D.S. charges \$35 for returned checks.*

*If you have any questions, please do not hesitate to ask. We are here to help you with the dentistry you deserve.*

*Patient Name:* \_\_\_\_\_

*Patient Signature:* \_\_\_\_\_

*Date :* \_\_\_\_\_

***Expect the extraordinary !!!***

*General Member of American Academy of Cosmetic Dentistry*

*140 Thomas Johnson Drive Suite 203 Frederick, Maryland 21702 301-662-8675 Fax 301-662-8975*