CULVER DENTISTRY FINANCIAL POLICY

We value our patients, and we are pleased to offer the following payment options so our patients will receive the dental treatment they need.

1: We will accept payment from your dental carrier.

The total sum of treatment is paid by personal check, all major credit cards, HSA cards as well as a debit card, and healthcare credit card such as Care Credit. If you use your HSA card, and there was overpayment. We will be more than happy to reimburse you by an office check. We will not be able to refund the HSA card after all dental claims have been paid and posted to your account.

2: The initial payment is 1/2 of the total sum. Then the balance is paid at the completion of the treatment.

3: The initial payment is 1/3 of the total sum. The balance is then paid for in two equal monthly installments.

4: The initial payment is 1/4 of the total sum. The balance is paid in three equal monthly installments.

5: If other financial options need to be discussed, please inform the office, and we will provide an option to help you receive the dental treatment you need.

COSMETIC PROCEDURES: Due to the length of the appointment time for cosmetic procedures, a down payment will be made by the patient to reserve the appointment. If the appointment is cancelled without 24 hours' notice a $75.00 nonrefundable cancelation fee will be deducted from the down payment. We understand that emergencies happen, each case will be decided on by the office and or the need to reschedule. This includes BOOST and any cosmetic procedures Veeners , Crowns, Full mouth restoration.

If you have dual dental insurance as a courtesy, we will file those claims as well. If all claims are paid and there is a balance the patient will be responsible for the balance. We appreciate your understanding of this policy. We look forward to continuing to serve you and your family.

I have been given a copy of the financial policy and I understand that payment is due at time of service, anything the insurance does not pay I am responsible for the balance.

Patient Signature: _____ Date: _____