GLOWING SMILE
DENTAL CARE

Financial Policy (for all patients)

Thank you for choosing us as your dental care provider. The following describes our Financial Policy. Our office is committed to providing you with the best possible care. **Your understanding of our financial policy is an essential element of your care and service**. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered. We accept cash, debit card, and for your convenience Visa, MasterCard, American Express, Discover and 3rd party financing through Care Credit. Please be advised that we do not accept check payments in the office.
Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. **Payment in advance may be required for certain treatment in order to reserve chair time and fund dental laboratory fees**.

Deposit Policy:

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 2 hours, we require a deposit of half of the treatment fee to make your reservation. _____initials

Appointment Policy (for all patients):

We will work hard to accommodate appointments that fit your schedule and dental needs. **We ask that you let us know about changes 48 hours in advance. We do understand that life happens, but any missed appointment without the 48 hour call may be subject to a $35 short/no notice fee, Habitual missed appointments are grounds for dismissal from the practice.** _____initials
All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies. We neither accept third party assignments nor do we recognize or enforce the terms of divorce or child support decrees.

I have read and understand the Financial Policy and Appointment Policy for A Glowing Smile Dental Care. I agree to abide by these policies.

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

Insurance Policy and Assignment of Benefits (for patients with dental insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date insurance carrier information, **restrictions** of your policy, and billing information. If your insurance company has not paid your claim in full within 45 days the remaining balance will automatically become patient responsibility._____initials

Please be aware some and possibly all of the services provided may Not be covered by your insurance provider. **Services, which are not covered, downgraded or fall under L.E.A.T (least expensive alternate treatment) by your insurance are your responsibility**. **Any balance left unpaid after 30 days will be sent to collections, these accounts will accrue a $35 delinquency fee in addition to any past due balance._____initials**

I hereby authorize my primary and/or secondary insurance company to make payments directly to A Glowing Smile Dental Care. Furthermore, I have read and understand the Insurance Policy for A Glowing Smile Dental Care. I agree to abide by these policies.

*Patient/Guardian Signature:*_____

Printed Name: _____

*Date:*_____