SUMMIT DENTAL GROUP

Payment & Financial Agreement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy. We offer the following methods of payment:

- **Payment in full** is due at the time of service. Cash, Check, Debit Card, MasterCard, Visa, Discover and American Express accepted.
- For patients with insurance, we will accept payment directly from the insurance company, but require that the deductible and non-covered fees be paid at each visit.
- We collaborate with Care Credit for a financing option. Applications can be completed online at www.carecredit.com or in office with the assistance of our receptionists. If approved, print off approval with our account number and bring to your appointment.
- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for child's co–payment.
- We offer a Prepaid Dental Program to patients without insurance. If you are interested in more information, please contact the front desk.
- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow Summit Dental Group to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.

Important Information Regarding Your Dental Benefits

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.
- **You** (not the insurance company) are responsible to us for all our fees for services rendered to you.
- An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.
- **BROKEN/MISSED APPOINTMENT:** Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for you convenience and hold great value. We require 48-hour notice of canceling or rescheduling your appointment, if 48 hours' notice is not given a $45.00 fee will be charged.

I acknowledge I have received and agreed to Summit Dental Group's Payment & Financial Policies.

Patient or Responsible Party: _____

Date: _____ Relationship to Patient: _____

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Credit Card Authorization

I authorize Steven J. Rollins, D.M.D. of Summit Dental Group to charge my credit card as follows:

Select your preferred type of authorization:

- ☐ **Continuous Authorization:** Summit Dental Group will keep this information securely on file to cover any unpaid account balances, (Patients will be notified prior to credit card being charged).
- ☐ **One Time Authorization:** Summit Dental Group will use this information **ONCE** to cover any unpaid balances after payment from insurance for treatment dated _____ through _____
- ☐ **Broken/Missed Appointment:** Summit Dental Group will use this information in the event of broken, missed, or rescheduled appointments without adequate notice to cover the $45.00 fee. Patients will be notified prior to credit card being charged.
- ☐ **Mutually Agreed Upon Payment Plan:** If patients require financial arrangements in the form of a payment plan to cover the cost of treatment, Summit Dental Group will arrange automatic monthly credit card charges per your request. (Agreed upon amounts may vary based on the cost of treatment.)
  - Please charge $_____ on or after the _____of each month for:
    ☐01 Month ☐02 Months ☐03 Months

(Final charge may also cover any unpaid balance on the account, which may be a greater amount than the amount listed above.)

- ☐ **Decline:** I do not wish Summit Dental Group to keep my Credit Card on file.

Credit Card Information:

Credit Card: ☐Visa ☐MasterCard ☐Discover ☐American Express

Card #: _____

Expiration Date: _____ /_____ CVV Code: _____

Cardholder Signature: _____

Printed Name: _____

Billing Street Address/Zip Code: _____

_____

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program. We appreciate the opportunity to serve you and thank you for being an important part of our SDG Family.

Patient or Responsible Party: _____

Date: _____ Relationship to Patient: _____