

DENTAL HOME CARE DENTIST

3960-A N.W. 26th Street • Miami, FL 33142
Office: (305) 871 5566 • Fax: (305) 876-0020

Patient's Name: _____

RESPONSIBLE PERSON FINANCIAL POLICY

Our philosophy is to make our patient's lives healthier and more comfortable by providing high quality, compassionate dental care.

In an effort to keep fees reasonable and to continue to provide quality care we have established a payment policy.

Our administrative team will be happy to bill your insurance carrier for you, however we do require payment of any services, to be paid at each appointment.

1. All routine dental treatment will be paid in full at the time treatment is rendered.
2. Cash, check, or charge cards are all acceptable forms of payment.
3. Extensive treatment programs should be paid on the date of the initial treatment and the balance up on delivery or completion of the treatment.

We have a financial coordinator who will be happy to help you with your individual needs. For larger treatment plans you will be given an ESTIMATE. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

A 1.5% interest rate will be charged on all unpaid balance in a monthly basis until the balance is paid in full.

I have read and understand the financial policy outlined about.

RP Name Print

Signature of Patient / or Responsible Party

Date