

OUR FINANCIAL POLICY

Welcome to our office! We are honored that you have chosen us for your dental care. We know that you are an individual with a unique financial situation. So we have worked hard to provide you with a variety of payment options. Now you can receive the dental care you need and enjoy the healthy and confident smile you deserve! In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. Payment is due when services are rendered unless other payment arrangements have been made in advance.
2. We accept payment by cash, check, Mastercard, Visa or American Express.
3. Fees quoted are accepted for 90 days. Should clinical conditions warrant a different treatment, we will inform you of changes in the fees prior to treatment wherever possible.
4. As a courtesy to our patients, we offer:
 - a. **An 8% prepayment discount:** To qualify for this discount, payment in full must be made at the initiation of treatment. This applies whether you pay by cash, check or credit card! (Does not apply to initial visit)
 - b. **Assignment of Benefits:** If your insurance company allows you to assign benefits to us, we will submit your claim and estimate the amount of your copayment. This amount will be due at the time of treatment. The courtesy discount does not apply in this case.
 - c. **Monthly Payments:** We can arrange comfortable monthly charges to your credit card each month. These will be applied directly to your dental care as it proceeds.
 - d. **Dental Credit Card or Line of Credit:** We have made special arrangements for you to obtain financing just for your dental care. These plans may allow you to pay off your debt with **no fees and zero interest** if repaid before a predetermined time period. This is a special benefit which we have obtained for our patients. Ask us to help you find out if you qualify!
 - e. **Dental Savings Account:** Make monthly deposits to your dental savings account and accumulate interest while you save!
 - f. **Group Dental Discount Plan:** Form a 4 member group and receive a **20% discount** on all treatment (Except initial evaluation and periodic checkups)!
5. Unpaid balances after 45 days will be subject to a 1.5% monthly finance charge.
6. A \$45.00 fee will be charged for all returned checks
7. Appointments cancelled without 24 hours advance notice will be charged a \$158 fee.
8. Certain appointments may require a deposit in order to reserve your time with the Dr.

"We work hard, so your dental visits are easy!"

MASTER PAYMENT PLAN SUMMARY

Patient Name: _____ **Social Security**

Home
Address: _____

Phone: _____

Employer
Address: _____

Phone: _____

Credit Card#: _____ **Exp date:** _____

I, _____, give the office of Dr. Terry S. Gotthelf permission to charge dental payment fees onto my (Visa, MC, American Express) credit card as detailed below:

Should insurance balance be overdue by more than 75 days, the remaining balance owed will be placed on this credit card.

Your Signature: _____