Because of the wide range of payment plans, this document will also spell out our credit procedures allowing us to minimize the paperwork you have to do and enabling us to serve you at a lower cost.

1. A 5% discount will be offered, to our uninsured patients, if payment is made, in full, by cash or check at the time the services are rendered.
2. If our patients prefer to pay by credit card, we accept Master Card, Visa, Discover, & American Express.
3. We will submit claims for approved insurance plans on your behalf.
4. The patient is responsible for any co-payments and/or deductibles. These are due, if known, at the time of the visit.
5. **Any open balances remaining longer than 60 days after contacting the applicable insurance plans and/or the patient/guardian, may be applied to the listed credit card.**
6. Any returned checks will have a $30.00 service fee added to the account.
7. Any outstanding amount that is 60 days past the date of service will be charged a 1% finance charge.
8. We offer 18 months interest free financing through Care Credit for approved patients.

Any appointment not cancelled with a 24 hour notice will be subject to a $25-$50 fee
_____ Initial

If you have any questions about your bill, or if you believe your bill contains an error, please call us immediately to discuss the situation. If the dispute cannot be resolved over the phone, then send a written inquiry to us within 60 days after the bill was mailed to your. Please provide in writing:

1. your full name
2. A descriptions of the error and why you believe the billing is in error
3. The dollar amount of the suspected error.

Thank you for your cooperation and allowing us to serve you.

I have read the above credit procedures and approve of their implementation.

Authorized signature: _____

Date signed: _____

Gentle Family Dentistry