

'Financial Policy

First Name - Patient

Last Name - Patient

Patient Date of Birth



Thank you for choosing Bella Sonrisa Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

- Cash, Visa®, MasterCard®, American Express® or Discover Card®
- CareCredit Healthcare Credit Card monthly payments

Payment Obligation: Bella Sonrisa Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received (laboratory costs are not refundable). We accept payment in thirds for treatments over \$800. For plans requiring more than 3 appointments, alternative payment arrangements may be provided.

Insurance: For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Your dental benefits are based upon a contract made between yourself or your employer and an insurance company. We are NOT involved in that contract. We estimate your portion based on the most up-to-date information we have, but it is only AN ESTIMATE. Ultimately you are responsible for payment so please be advised that if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees.

Missed Appointments: We understand that sometimes circumstances arise that prevent patients from keeping appointments. If you need to reschedule an appointment, please contact the office 48 hours in advance to avoid a charge of \$25.00.

Patient Payment

I, the patient or Responsible Party (account holder), agree to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement. Furthermore, I authorize release of any information relating to this claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance.

Print name

Signature

Clear