MOUNTAIN VIEW DENTAL, PA – FINANCIAL & PAYMENT OPTIONS

Thank you for choosing our practice. Our primary mission is to deliver the best and most comprehensive dental care available. Your clear understanding of our financial options is important to our professional relationship.

PAYMENT OPTIONS:

- Cash
- Personal Check
- Visa, Mastercard, Discover
- Care Credit- a third party no interest* payment plan (*dependent upon terms)

Please Note: Insurance is a contract between you and your insurance company. For patients with "dental insurance" (or a dental benefit plan), we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, our contract is with you, not your insurance company. Our staff cannot be responsible for knowing all the terms and limitations of the many policies of our patients. It is your responsibility to familiarize yourself with your dental care policy and be aware of any uncovered charges or limitations of your plan.

We require payment at the start of your treatment. Please be prepared to pay your deductible and any estimated amount not covered by your insurance plan at the time of your visit. Payment in full is required for all dental plans who reimburse the subscriber directly. For larger, more comprehensive treatment plans of $500 or more, a 50% deposit may be required to secure your initial treatment appointment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For treatment plans requiring multiple appointments, alternative payment arrangements may be provided. A **Pre-Pay Courtesy** of 5% will be subtracted from the total if the entire treatment plan balance (of $500 or more) is paid in full, with cash or check, at least 48 hours before the start of treatment (for non-insured patients).

We assess a charge for all non-sufficient fund checks.

Patients are responsible for all charges (whether paid by insurance or not). Unpaid balances over 90 days may be processed through a collection service and the patient will be responsible for any additional collection charges.

I have read, understand and agree to this Financial Policy.

_____ _____

Signature of Responsible Party (Patient, Parent or Guardian) **Date**

Relationship to Patient: _____