SOUTHSIDE DENTAL

OUR PRACTICE'S PAYMENT INFORMATION

When it comes to spending your hard-earned money, most people have questions. The below is an attempt to answer some of those questions. Please sign to confirm your understanding.

- We ask that payment due from dental services rendered to you and your dependents be *paid at the time of service*. We strive to advise you of this estimated amount prior to your treatment. If we do not provide you this information, please request it. We want you to know what you are expected to pay.

- If you have dental insurance, we give an estimate of your portion due from your insurance company and ask that you pay only that amount at the time of service. Insurance benefits are sent directly to our office and will be applied to your account.

- Insurance and the human body are unpredictable; therefore, the estimates we give you are only that, an estimate. Due to this inherent unpredictability, after your insurance pays, there could be a balance or a credit on your account. If there is a balance, we will send you a statement requesting your payment on receipt of the statement. If what remains is a credit, we can send you a check for that amount.

- We want you always to feel free to call us with questions or concerns about your charges, statements, insurance, or clinical issues. We are here to help you.

- Overdue accounts are referred to an attorney or collection agency. Any fees or costs incurred for the collection of amount due is the responsibility of the patient, parent, or guardian. This includes court costs, interest fees, attorney's fees, and collection agency fees.

- Any balance due over 90 days old will incur a 3% per month late charge.

OUR PRACTICE'S PAYMENT OPTIONS

1. **CASH/CHECK/MONEY ORDERS**
2. **VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS CREDIT AND DEBIT CARDS**
3. **CARECREDIT**: For those interested in monthly payments

We can help you afford the dental work you need and want. Please call our office and ask to discuss specific ways in which to make it a reality. 423.265.3471

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE _____ ***RELATIONSHIP TO PATIENT*** _____