TREMAN & TREMAN FAMILY DENTAL CARE
Financial Policy

Welcome to Family Dental Care! We are happy that you have chosen to pursue your dental health with us. We look forward to providing you and your family with excellent dental care in a comfortable atmosphere, at a reasonable cost, using state-of-the-art technology and the finest materials available.

To enable us to provide you with exceptional and affordable care, our Financial Policy is as follows:

1. If your fee was not collected when we reserved time for you on our doctor's schedule, payment is required on the date of treatment. As a courtesy to you, we offer interest free financing (up to12 months) with Wells Fargo Bank and Care Credit®*. Applying for this opportunity takes just a few moments. Extended low interest plans are also available. Ask any team member for additional information. **Children**: Fees for children under the age of eighteen are the *responsibility of the adult accompanying the child unless other prior arrangements are made in writing.* This precludes any custodial or financial agreements between parents/guardians. **Dependents over the age of eighteen** are considered adults and *assume responsibility for payment of all procedures unless prior arrangements are made in writing.*

If financial arrangements are required these must be completed* before *treatment has begun.

We accept ~Cash ~Check ~Visa ~MasterCard ~Discover ~American Express ~ Wells Fargo ~ Care Credit

2. **Insured patients:** You will be expected to pay all co-payments and deductibles at each date of treatment. We will make every effort to provide you with an estimated co-payment for each procedure. Estimates quoted are based on the information provided to us by you and your insurance carrier. ***The exact amount cannot be known until treatment is complete and your carrier reviews your claim.*** As a service to you we will promptly file your claims with your carrier when you provide us with accurate dental insurance information. Insurance payments not received after 45 days from filing will be considered denials. Balances remaining after payments or denials should be paid promptly.

3. **Initiation of restorative treatment**, (i.e. crowns, bridges, partials, dentures, implants, etc.) and root canal therapy *obligates the patient to accept responsibility for payment and* ***completion*** *of the treatment*. **Further, you must commit to ongoing semi-annual dental exams and preventive visits to maintain the integrity of your restorative treatment and any implied or explicit guarantee.**

4. The Federal "**Red Flag Law**" requires that we maintain a picture ID for each patient on file. This is intended to protect you against identity theft resulting in unauthorized use of your insurance benefits or bank accounts.

With my signature below, I acknowledge that I have read the financial policy outlined above and understand and accept my responsibility as outlined therein.

_____ _____

Signature of Patient or Parent/Guardian Date

Name of Patient if signing as Parent/Guardian _____

**Subject to credit approval. Ask for details*

As a valued member of our patient family, our doctors and staff welcome the opportunity to answer any questions that you may have regarding any aspect of your care