Dorsch
family dental

Payment in full is expected at the time of treatment. The patient or guardian is responsible for payment of services provided regardless of contracts with dental benefit plans. We will gladly pre-authorize treatment estimates with your benefit provider for major treatment. Our office is happy to accept your estimated copayment and bill your benefit provider for the remaining amount. If the actual insurance payment is less than the estimated payment, or if the claim is denied, your account will carry a balance for which you will receive a monthly statement. Accounts not paid in full within 30 days from statement billing will accrue a 1% fee per month not to exceed 12% annual.

The estimated insurance payment is not a guarantee of coverage, payment or authorization. Payment is subject to plan provisions, including deductibles, plan maximums and exclusions, fee schedules and patient eligibility at the time services are actually performed.

There are times when planned treatment becomes more extensive. You will be informed of these changes at the first available opportunity, including alternative treatment options and fees.

Payment Options

ZERO BALANCE: 5% courtesy for payment in full at the time of service.
MAJOR CREDIT CARDS: Visa, MasterCard, American Express.
CARE CREDIT: We can assist you in applying for credit for dental services through a program called ***Care Credit***. Ask our staff about this option.

Patient Name: _____

Responsible Party: _____

Statement of Understanding

I understand the financial arrangements and agree to comply with them. I agree that parents and guardians are responsible for all fees and services rendered for treatment of a child. I understand that I am responsible for all fees regardless of insurance coverage. I also understand that when treatment is rendered the fees may have to be adjusted, but that I will be informed of these adjustments. In the event that my payments are not received within 30 days of their due date that I will incur a 1% fee per month not to exceed 12% annual.

Responsible Party Signature: _____ **Date:** _____

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