R. Renan
Williams DDS
General Dentistry
5104 Eldorado Dr.
North Richland Hills, TX 76180

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we strive to offer convenient payment options, while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an **estimate** of your treatment costs. We welcome you to our family and look forward to helping you get the healthy, beautiful smile we know you deserve.

FINANCIAL OPTIONS

A. **Full Pay Discount:** We offer a 5% courtesy for all treatment that is paid in full (cash or check) at the time of service **– cannot be combined with options B. or C.**

B. **Care Credit:** For our patients who want to make monthly payments. We offer short and long term financing through Care Credit.***Our front office will gladly assist you with the application process**

C. **Co-Payment:** Our goal is to help you maximize your dental insurance benefits. We have verified your insurance coverage and are required to collect from you the amount they notify us is due from you. Our **estimate** is as accurate as we can make it but is subject to change when the insurance company makes payment. **As a courtesy**, we are happy to bill your dental plan for services. Please remember that your contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 45 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. Also remember that dental insurance plans are not designed to cover all your needs. Rather, the amount your dental plan contributes toward your dental care is based on the plan selected and purchased by your employer.

*For treatment requiring more than 2 appointments, alternative payment arrangements may be provided.

FINANCIAL POLICY

If my insurance claim has not been paid in full after 45 days it will become my responsibility to pay at that time. For any balances over sixty days, interest will accumulate at the rate of 1% per month. **I understand that a fee of $35 will be charged per reserved hour of chair time for miss/cancelled appointments without a 24-hour notice. I understand a fee of $25 will be charged for any returned check.** If for any reason my account is turned over to a collection agency, I understand that I am held responsible for any collection fee & interest incurred due to collection efforts.

I accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. **I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or underpaid by my insurance carrier.**

Patient Signature: _____ **Date:** _____
(Patient, Parent or Guardian)