INSURANCE AND FINANCIAL POLICY

At Boeding and Speltz Family Dentistry, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients.

If you **DO NOT** have dental insurance:

Our office does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash and checks. We also offer 5% prepayment courtesy for any treatment over $500 when account is paid in full.

If you are in need of an extended payment arrangement, we also work with Care Credit, who offers 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

If you **DO** have dental insurance:

We will bill your insurance as a courtesy. Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. We work with literally thousands of insurance companies. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

Our office does require payment in full for your portion at the time of service. If your insurance does not pay within 90 days, Boeding and Speltz Family Dentistry requests payment in full from you and you collect from the insurance.

We accept MasterCard, Visa, Discover, cash and checks. We also offer 5% prepayment courtesy for any treatment over $500 when account is paid in full.

If you are in need of an extended payment arrangement, we also work with Care Credit, who offers 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

We cannot guarantee any or all payment by your insurance company. Not all dental services are covered by insurance. Some plans may have waiting periods that apply to certain procedures. Ultimately, you are responsible for all charges incurred in our office.

I agree with the above conditions.

Print Name:_____Date:_____

Patient/Parent Signature_____