Financial Policy

Florence Family Dentistry
David L. Smith, D.M.D., P.C.

We would like to keep our fees as low as possible. Therefore, **payment will be due on the day services are rendered.** For your convenience, we accept **Cash, personal checks, VISA, and MasterCard.** For more extensive dental treatment plans, **CareCredit** is also available. **Special note for patients with *Insurance!!*** We strive to help our patients maximize their dental plan benefits. To minimize your out of pocket expense at the time of your visit, we will submit for direct payment of your dental plan benefits. We do ask that **you pay your estimated payment portion and deductible** (if applicable) **on the day of treatment!!**

Upon receipt of your company's dental plan payment, we will refund any credit or bill the balance to you. Balances and credits of less than $5.00 will be kept on account. Please understand that our services are provided to you, the patient, and not your insurance company. Please pay close attention to your available insurance benefits. If you exceed the set annual maximum in this, or any other office, you are ultimately responsible for the remaining balance. Therefore, **you,** and not the insurance company, are responsible for any unpaid balance on your account.

Please note that our office will apply a monthly finance charge of 1.5% (annual percentage rate of 18%) on all account balances over 30 days. All accounts that are submitted for collection to an agency will be subject to an additional charge equal to 35% of account balance.

If you do not show up for a scheduled appointment, a $50 fee will be automatically charged to you. If scheduled appointments are repeatedly cancelled and/or rescheduled without 24 hours notice a $50 fee will be assessed to your account.

I have read and agree to the financial terms for this office.

Patient Signature:_____ Date:_____

If patient is a minor,
Parent or Guardian
Signature:_____ Date:_____

I Understand Dr. Smith and/or his employees will be taking intra-oral pictures. These pictures are, but not limited to, teeth, tissue and lips. I give my permission for Dr. Smith to use these pictures for educational and advertisement purposes. Pictures used will not have any personal information attached or advertised.

☐ **Yes,** I will allow Dr. Smith to use pictures ☐ **No,** Thank You