FINANCIAL POLICY OF BRAINERD DENTAL CARE LLC

Thank you for choosing Brainerd Dental Care, LLC for your dental needs. We are committed to providing you with best possible care. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the care that you need and want with respect to your budget. It is also very important that you have a clear understanding of our financial policies before we begin treatment.

We are happy to submit your claims and help you with any insurance questions in order to maximize your benefit. This is done as a courtesy to you, but the ultimate responsibility for understanding your policy lies with you. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges.

Insurance patients will be asked to pay an estimate of their patient portion at time of service. You will receive a monthly statement of the remaining balance once your insurance has paid. Payment will be expected within 30 days of receipt unless you contact us to initiate an alternative arrangement.

If you do not have insurance, payment is due at time of service unless advance arrangements have been agreed upon.

Payment options:

1. Cash or check (5% discount if paid in full at time of service)
2. Visa or MasterCard
3. Flexible Spending Accounts
4. CareCredit – the financing plan we offer as a separate line of credit to cover your healthcare needs. CareCredit offers many benefits, including:
   **No interest or revolving plans @11.9% interest
   **Flexible financing options
   **No annual fees or prepayment penalties
   **Apply through us or privately by phone or online

If your account is sent to collections, it will be documented in your financial record. You will not be scheduled for future appointments without approval. Returned checks will be subject to a $25.00 fee.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company are my responsibility. I understand that it is my responsibility to contact my insurance carrier if they do not respond to payment requests made on my behalf.

Print Name:_____

Signature:_____

Date:_____