

Payment Options and Financial Agreement For University Suburban Dental Group, Inc

University Suburban Dental Group, Inc. strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. Our goal is to help you afford your dental choices. Please take a moment to review the financial options offered and indicate your choice of payment. Thank you.

Plan A: Cash or Check

To demonstrate our appreciation for patients who pay IN FULL on the day of the visit, we will extend 6% reduction of the total fee. This applies to services only and not products purchased at point of service.

Plan B: Credit Card

You may use your credit or debit card to make payment. We will gladly accept MasterCard, VISA, Discover, or American Express.

Plan D: Care Credit (Third Party Financing)

We are pleased to offer our patients another extended monthly payment plan option; Care Credit Financing, which has a no-interest payment plan for balances over \$300. *Please see our Financial Coordinator to receive a loan application to determine eligibility for this payment program.*

Plan E: Insurance Benefits

As a courtesy, we are happy to bill your plan for services rendered to you. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. You will be due deductibles and/or copayments at the time of service if applicable.

I, _____, have chosen option _____ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that a 1.5% Finance Charge, or a minimum of \$3, will be added to any outstanding balance over 90 days from the date of service.

In regards to insurance, if applicable, I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and give the dentist the authority to release all information necessary to secure the payment of benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I understand that dental insurance does not cover all dental costs and if a service is deemed as non-covered by my insurance plan it does not mean the service is not necessary. By signing this Agreement I acknowledge and agree that I will be financially responsible for the full amount of a service not covered by my insurance plan and/ or any balance remaining after my insurance plan pays.

Broken Appointment Policy: I understand that a broken appoint occurs when I fail to appear for a scheduled appointment without proper notification or cancel a scheduled appointment with fewer than 24 hours notification. I also understand that the associates of USDG, Inc. reserve the right to charge a \$75/hour fee for any unfilled appointments resulting from my failure to contact the office as stated above.

Please feel free to contact our Financial Coordinator at 216/381-6521 if you have questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

Patient Signature: _____ Staff Signature _____

Date: _____