# Veronica M. Enriquez, D.D.S.

## Payment Policy

We make every effort to keep down the cost of your dental care. You can help by paying in full after each visit. You may request a written estimate of the charges for any procedure.

We feel that everyone benefits when there is a definite and clear financial agreement prior to treatment. To make your financial arrangement as easy as possible we accept the following methods of payment: Cash, Check, Visa, MasterCard, and Debit cards.

____ Option 1 Payment in full is due the day of treatment. A five percent (5%) reduction is made if paid by cash/check/or debit card. (Option 1 is for those patients that are **not** utilizing insurance.)

____ Option 2 Divided payments (for amounts over $1000.00) of up to three equal monthly payments can be arranged by **automatic billing** on your credit card. First payment is due on the day treatment begins. (Option 2 is for those patients that are **not** utilizing insurance.)

____ Option 3 A claim will be submitted to your insurance company for all covered services. Your deductible and copay, if any, will be due and collected at the time of service. If your insurance pays you, the patient directly, payment in full is expected at the time of service. Our office will submit claims on your behalf. No payment arrangements may be used with this option.

We will be happy to file your insurance as a courtesy: **however, any balance still due after 90 days will become the patient's responsibility and a finance charge (24% annually) will begin to accrue monthly.** Your insurance is a contract between you and your insurance company. It is the patient's responsibility to know their insurance benefits and to make sure that their claims are paid within a timely manner.

Self-pay patients making full payment on the day of service, will receive a 5% discount. (Cash, Check, or Debit Card only**). If you are unable to keep a scheduled appointment, you need to notify the office within 48 hours or a $50.00 broken appointment fee will be assessed to your account.**

In the event of a returned check, there will be a $35.00 return check fee charged to the patient's account and the account must be paid in full within 10 days to avoid further collection activity. If an account is turned over to a collections agency, the patient/parent/guardian is responsible for all collection charges, including court costs, plus all reasonable attorney fees. The additional collection charge will be at least 35% of your **TOTAL** balance.

I have read and fully accept the policies mentioned above. This signature on file is my authorization for the release of information necessary to process my claim, and that I accept full responsibility for all charges incurred.

Signature _____ Date _____

Print Name: _____