



## FINANCIAL

Thank you for choosing us as your dental care provider. We realize that everyone's financial situation is different. For this reason, we have worked hard to provide a variety of payment options so that you can receive the care you deserve with respect to your budget.

**Please check the option(s) that will work the best for you.**

**Pay As You Go (w/ Insurance Processing)**

You may use Cash, Personal Check, Debit, Visa, MasterCard, Discover, American Express, and Money Order to pay your estimated portion owed at each visit.

**Pay As You Go (No Insurance Processing)**

If we do not have to file insurance claims and wait for payment from an insurance company, we offer a **5% accounting discount** when you pay the **entire balance owed at each visit**. If you do have insurance and still want to take advantage of this discount, we will print the claim for you and you can receive payment from your insurance company.

**Entire Treatment Plan (No Insurance Processing)**

If we do not have to file insurance claims and wait for payment from an insurance company, we offer a **10% accounting discount** for larger cases when you pay **up front for your complete treatment plan (all visits needed) before the start of treatment**. If you do have insurance and still want to take advantage of this discount, we will print the claim for you and you can receive payment from your insurance company.

**Monthly Payments**

With **no down payment** required and **small monthly payments**, this is the most favorable option for many of our patients. We use several different, high quality finance companies which specialize in helping dental patients afford necessary treatment. There is no deposit required, monthly payments can be as low as 3% of the outstanding balance, and terms range from 3 to 48 months. There is **no interest** for any program of 3, 6, or 12 months. Longer terms have reasonable rates (much lower than standard credit card rates) and there is never any prepayment penalty. Approval takes just a few seconds and is done right here in the office.

## INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service you will be required to pay your **estimated** co-payment. Please understand this is only an **estimate**, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Once your insurance carrier has paid the claim, any difference will be due within 30 days. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the full balance will be your responsibility.

## AGREEMENTS AND CONSENT TO PROCEED

- I authorize Bishop Dental to take X-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor and to perform any and all forms of treatment, medication, and therapy that may be indicated. I do voluntarily assume any and all possible risks associated with the delivery of such treatment.
- I authorize Bishop Dental to receive payment directly from my insurance company for all services rendered to me and my family.
- I agree to pay monthly interest charges in the amount of 1.5% per month on all charges over 30 days old.
- I agree that should my account ever be referred to an attorney or collection agency, I will pay all costs of collection, including up to 40% collection agency fee, as well as court costs and a reasonable attorney fee.
- I authorize Bishop Dental to obtain a credit report when deemed necessary.
- I have been allowed to review and to receive (if requested) a copy of the offices Notice of Privacy Practices.

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Signature of Patient (Parent or Guardian if patient is a minor)

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Date