

DFW SMILES

2700 William D. Tate, Suite 100
Grapevine, TX 76051
(817) 281-3444

Financial Policies

In an effort to keep dental fees down while maintaining a high level of professional care, we have established the following plans for our patients:

1. Payment in full is due for each visit unless financial arrangements have been approved in advance by our staff.
2. For patients with no dental insurance, the total fee amount is due and payable at the time of treatment. We accept cash, check and the following bankcards: Discover, Visa, MasterCard and American Express.
3. While the patient is responsible for the total cost of treatment, as a courtesy we will file insurance on the patient's behalf. At the time of service, we **estimate** the insurance payment and collect the patient portion not covered by insurance. Payments from dental insurance companies are accepted. However, the patient is responsible for any remaining balance after **45 days** from the date of service, regardless of the status of insurance claims.
4. A 5% cash discount is given on any total amount due over \$1000.00 if paid at the time of treatment.
5. One-half of the total fees may be paid when treatment is started, with the balance due when the treatment is completed.
6. Divided Payment Plan: Financial arrangements may be made through an outside lender by the name of Care Credit. Payments are available for both 6 and 12 months. We also allow prepayment for any dental treatment.
7. A 10% courtesy discount is given to senior citizens 63 and older for both cash and credit card payments.
8. To better control the cost of dental care, guidelines have been established regarding missed appointments. A fee of \$25 will be assessed for an appointment cancelled with less than 24 hours notice. A \$50 fee will be assessed for an appointment missed without prior notice.
9. All accounts over 60 days old are considered delinquent and payable immediately. If payment is not received by 90 days, the account is referred to an outside collection agency or attorney's office and is reported to the credit bureau. The patient or responsible party is responsible for all attorney and/or collection agency fees and court costs.

**As always, our primary goal is to provide the finest dental care available to all our patients.
Thank you for your cooperation in assisting us in the process.**

Signature: _____ **Date:** _____