Anderson Dental Group
Creating Beautiful Smiles Since 1971

Written Financial Policy

Thank you for choosing Anderson Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care on treatment cost of $500 or more. Discount is not valid in conjunction with any other offer or promotion. **Any unpaid balance after 30 days will incur a 18% financial charge.**

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Anderson Dental Group requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

A fee of $35 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

Anderson Dental Group charges $25 for returned checks.

Insurance is a contract between you and your insurance carrier, therefore it is your responsibility to be informed of your policy's benefits, frequencies, exclusions, and limitation details. [2]For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. Please be advised that we will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than supply factual information as necessary. ***You are responsible for the timely payment of your account.***

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.