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Pediatric Dentistry
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Office Financial Policy

Thank you for choosing Rochester Family Dental. 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 or Discover Card
  - We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash at commencement of treatment plans of $500 or more.
- NO INTEREST Payment Plans from CareCredit *(subject to credit approval)*
  - Allow you to pay overtime with NO INTEREST
  - Convenient, low monthly extended payment plans also available *(with interest applied)*
  - No annual fees or pre-payment penalties

Please note:

- ✓ For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. You are expected to pay **your** estimated portion at the time of service. If your insurance carrier pays you, the subscriber, directly, we will expect full payment at the time of service unless payment arrangements are made ***in advance***.
- ✓ A minimum fee of $50 per appointment is charged for patients who break or cancel appointments without 24-hour notice.
- ✓ A $25.00 service charge will be billed to your account for all returned checks.
- ✓ A service charge of 1.5% per month will be charged to your account on any unpaid balance after 30 days.

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

It is understood and agreed that in the event that any outstanding balance has to be referred to a collection agency or attorney for recovery that the patient will be fully responsible for any costs, including, but not limited, to attorney's fees. Any other payment arrangements, which may have been made, do not affect any of the terms of this policy.

_____ Date: _____
(patient, parent or guardian signature)

_____ Date: _____
(patient name – please print)