PARADIGM

Even Our Name Smiles

PAYMENT OPTIONS

Paradigm Dental Center, LLC ® strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an **ESTIMATE**. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate your choice of payment**. Please initial the plan that applies to you.**

____ **Plan A**: I have no insurance and will be paying out-of-pocket. I understand that I can receive a 10% discount off of the TOTAL costs of ALL the services I needed if I pay in advance. (This does not include treatment for just one or two teeth unless that's all the treatment to be done.)

____ **Plan B**: I have no dental insurance, and I am interested in applying for monthly payment options. *Please see our receptionist prior to treatment for more details and to receive an application.*

____ **Plan C**: I am a senior citizen (65 and older) with no dental insurance. I understand that I can receive 5% off of ANY of my services. If I pay in full for all needed treatment needed, I will get 10% off.

____ **Plan D**: I have insurance. I understand that I am responsible for any copayments. If the insurance company has not paid after 60 days, I am responsible for any remaining balance. I understand that the office does not file secondary insurance claims but provides the paperwork for me to do so.

A Note to Our Patients with Insurance

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of your coverage, your estimated co-payment or deductible is due in full the day of treatment***. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balances and seek reimbursement from your dental plan.*** Also remember that dental insurance plans are not designed to cover all of your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.

You may be assessed a $50 cancellation fee if we are not called <u>at least</u> 24 hours in advance should you need to cancel your appointment. There is also a $30 returned check fee should your check be returned. You may be sent to a collection agency if you do not pay any outstanding balance after your insurance company makes its final payment. Please initial that you understand.

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Again, feel free to contact any member of our staff if you have questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I,_____, have chosen the above options initialed and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. ***I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits.*** I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment**.** ***I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time***.

Patient Signature:_____ Date:_____