Payment Options
For
Yorkshire Family Dentistry

Yorkshire Family Dentistry 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.

□ **Plan A:** Payment in full on the day of each visit. Cash, Check, Visa, Master Card Or Discover

□ **Plan B:** We are pleased to offer our patients another extended monthly payment plan option through a dental financing company called Care Credit. Please see our receptionist prior to treatment for more details.

□ **Plan C:** Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. You are fully responsible for any and all charges your insurance does not cover. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay an outstanding balance 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.

Once your appointment has been made please remember this time has been reserved especially for you with one of our dental professionals. We ask that you give us 48 hour notice if you are unable to keep your reserved time. Not doing so may result in a $35.00 fee.

I, _____, have chosen option _____ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. **A finance charge of 1-1/2% per month, which is an annual rate of 18%, is charged on all past due accounts**. 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:_____ Staff Signature: _____

Date: _____