ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I understand that for my convenience Boone Endodontics accepts Cash, Check (submitted electronically), Visa, MasterCard, Discover or Care Credit. We can help you apply for Care Credit.

Full payment is expected at the time of service unless prior arrangements have been made and approved by Boone Endodontics.

In case of default, the patient/responsible party is liable for any and all collection and/or reasonable attorney fees.

We offer a 3% discount if you pay your entire treatment in full with cash or check. We provide no discounts for the consultations.

IN-HOUSE FINANCING/ Pre-Authorized Credit Card Payment Agreement:

Qualifying patients may receive in-house financing for up to 50% of their treatment fee. If approved for in-house financing:

a) I understand the consultation appointment must be paid in full at the time of service.
b) I will pay at least 50% of my treatment fee on the day of the treatment.
c) I agree to complete a **Pre-Authorized Credit Card Payment Agreement**, agreeing to make monthly payments that will pay off my balance within 90 days.
d) I understand and agree that by using the in-house financing, an additional monthly maintenance fee of 5% of the financing balance will be added to each credit card payment.
e) I agree that if my balance is not paid in full by the agreed-upon date on the **Pre-Authorized Credit Card Payment Agreement**, I will be charged an additional late fee of 15% of the monthly payment per month until the balance is paid.

FOR PATIENTS WITH DENTAL INSURANCE COVERAGE:

As a specialty office, Boone Endodontics is ***not*** in network with ***any*** insurance provider. As a courtesy, Boone Endodontics will file my dental insurance claims electronically on my behalf. I understand that I can decline having my insurance claims filed on my behalf.

Dental insurance claims can be filed to all dental insurance carriers with the exception of Medicaid/Medicare and NC Health Choice. I understand that my insurance carrier will mail the reimbursement check directly to me. I understand that I will be expected to pay for my service at the time of services.

I understand and agree to the following options:

a) I will make payment in full at the time of service.
b) I agree to pay 50% of my treatment fee at the time of service if I qualify and arrange in-house financing.
c) I agree to fill out a **Pre-Authorizing Credit Card Payment Agreement**, authorizing Boone Endodontics to charge my credit card for any remaining balance that is not paid at the time of service as per the agreement.
d) I understand that if my insurance carrier mails the reimbursement check to Boone Endodontics, the reimbursement will be applied to any remaining balance and I will be contacted for any overpayment.
e) I agree, in the event that my insurance carrier mails the reimbursement check for my treatment directly to me that I will contact Boone Endodontics immediately with payment in full for any balance due.
f) I agree that any balance not paid in full within 90 days of my service date will be charged a late fee of 15% of the remaining balance per month.

I have read and understand the Financial Policy for the above named practice.

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Signature of patient or legal guardian Date