SCHOENING DDS

Financial Policy

First name: _____ Last name: _____

Payment Options (please check how you plan to pay for today's visit)

_____Cash _____Check ____Major Credit Card ____Care Credit

Patients without Dental Insurance

- Our office policy requires that payment is due in full on the date of service

Patients with Dental Insurance

- We will file your insurance as a courtesy to you, but we do expect your estimated payment and necessary deductible to be paid at the time of service
- The estimated co-payment is merely an estimate and not a guarantee of payment by your insurance company
- You must provide the name, address, and phone number of your insurance company in order for us to submit a claim form. If not provided, you will be required to pay for your visit in full and let your insurance company reimburse you.
- After 60 days any unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Please Note:

- *All returned checks will be subject to a $25 fee*
- *There will be a $50.00 charge per hour on appointments that are not cancelled 48 hours prior to the appointment*

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my dental care. I hereby authorize payment of my dental benefits to Schoening DDS.

X _____ _____
Signature of patient Date

X _____
Signature of parent/guardian