Financial Arrangements

Fees for dental services are due at the time of treatment. As a courtesy, our office will file with your insurance company for treatment provided.

We are able to offer the following options for payment:

Schedule

Upfront Payment Cash/Check
For cases over $1000, we offer a 5% courtesy discount for treatment paid-in-full at the start of treatment with cash or check. If you have insurance, any insurance payment to us will be refunded directly to you.

Split Payment
50% of the fees paid at the start of treatment and 50% of the fees paid before delivery of prosthesis.

Methods

Cash/Check

Credit Card
We accept VISA, MasterCard, Discover, American Express, Diners Club, and PayPal credit cards. With your consent, your credit card may be used for month payments.

CareCredit
As a service to you, we have partnered with CareCredit to offer extended financing options. They offer some 0% interest options and some plans up to 60 months. This effectively becomes a loan between you and CareCredit. You can apply directly by calling 1-800-677-0718 or visiting *http://www.carecredit.com/doctor-locator/results/Palmetto-Prosthodontics/* Feel free to ask us for help to apply.

Insurance
Because dental insurance is a contract between either you or your employer and a dental insurance company, any fees not covered by insurance will become the patient's responsibility. You will be responsible for any estimated portion that is not covered by your insurance plan. 50% of this amount will be due at the time services are rendered and the balance due before delivery. Once insurance payment is made, you will be informed of any remaining balance or credit.

I, _____ understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependants in the dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature: _____

Date: _____