Newark Smiles Financial Guidelines
1619 West Main Street
Newark, OH 43055
(740) 522-1133

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health.

The following explanation is intended to promote a better understanding of our financial policy and to develop a comfortable relationship between patient and doctor. We require you to read and agree to sign this policy prior to the start of any treatment at Newark Smiles. In our ongoing effort to keep dental treatment costs down, while maintaining a high level of professional care, we have established the following payment arrangements for the benefit of our patients.

FOR PATIENTS WITHOUT DENTAL INSURANCE

We require all procedures to be paid for at the time of service. Ask about our "IN HOUSE" dental plan for those without insurance. We offer the following payment options:

1. Cash, Check, Visa, Master Card, Discover & American Express
2. Flexible payment plans upon approval with Care Credit and Wells Fargo (up to 12 months with no interest)
3. 3 month payment plan with credit card on file (no discounts apply)
4. 5% discount with payment in full for all patients without insurance
5. 15% discount with payment in full for patients who have our Patient Care Plan

FOR PATIENTS WITH DENTAL INSURANCE

We will submit all insurance claims for you and will fully attempt to help you receive full insurance benefits. You will need to pay the estimated co-pay at the time of service, and we will adjust your balance, if necessary, after insurance pays the claim. However, it is important for our patients to understand that **all insurance benefits quoted are an ESTIMATE** and our patients are ultimately, personally responsible for the remaining balance on their account. Please remember that an insurance policy is a contract between you, your employer and the insurance company, not us. If, after 60 days, the insurance company has NOT paid its portion of the treatment fees, then the patient is responsible for the bill**.** If we are unable to verify your dental coverage, you are responsible for payment in full at the time of service. ***Please call your insurance company to verify your benefits if you have any questions.*** I hereby assign to the dentist, all payment for dental services rendered. I have read and understand the above financial policy. Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents. I authorize Dr. Shah and associates to furnish information to insurance carriers concerning my dental treatment or my dependents treatment.

FOR ALL PATIENTS

If you have any questions, please let us know. Thank you for giving us the opportunity to serve your dental needs.
I acknowledge that payment is due at the time of service, unless other arrangements have been made. By signing this form, I authorize Newark Smiles to process credit card transactions initiated by me, either by mail or phone, and I authorize my credit institution to pay Newark Smiles. I have read and fully understand my financial options and obligations.

Signature of Patient or Responsible Party **Date**

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Print Name of Patient

September 2017

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