M. VERONICA PUNLA SMITH DDS
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OSHKOSH, WI 54902
920.231.8120

PAYMENT OPTIONS AND TERMS

Thank you for choosing our office for your dental needs. We are committed to providing you with quality dental care in a comfortable and friendly atmosphere. We believe dental treatment is an excellent investment in an individual's overall well-being.

PAYMENT OPTIONS – Full payment is expected at the time of treatment using one of our convenient payment methods. These include dental benefits, cash, check, credit card or CareCredit. For those without dental benefits, a discount of 5% is given for payment in full by cash or check at the time of service. For patients who are 65 and older, a 10% discount will be given.

- **Full payment is due at the time of service.**
- **We accept payment by cash, check, credit, CareCredit, and most insurance plans.**
- **We provide insurance billing as a courtesy to our patients. The patient portion of any particular dental service is estimated and due at the time of service.**
- **We are preferred for a growing number of dental insurance companies.**

DENTAL INSURANCE – Dental plan benefits are determined by a negotiated contract between your insurance company and we are not a party to that contract. As a courtesy to you, we are happy to file your dental benefit claims and assist you in maximizing these benefits. Most plans are intended to assist with the cost of treatment and seldom offer full coverage. Since our office cannot guarantee individual insurance payments, the patient is responsible for verifying their benefits and for any amount that is not paid by the policy. We'll do our best to use our experience to help you through it. We will **estimate** the covered portion and will assist you in determining your responsibility for treatment. Any portion that is not covered by insurance is due by you at the time of service. If for any reason the estimate was incorrect, we will send you a statement for the remaining balance or a credit for overpayment. Please call our office if your statement does not reflect your insurance payment and we will be happy to check the status of your claim. We encourage you to review your policy so you are aware of your plan specifics.

CANCELLATIONS – Our clinical specialists reserve your appointment time exclusively for you. We kindly request a 24-hour notice to cancel or reschedule and appointment. If you fail to show up for your appointment, or have excessive cancelled appointments, you may be billed for the time that was reserved for you.

PARENTS – The adult who accompanies a minor to an appointment is responsible for payment on the day of minor's treatment using one of our convenient payment options. If the minor will be coming alone or with a caregiver, please make arrangements with our office in advance. The adult(s) who signed the registration forms will receive billing statement for any additional fees that are due.

MULTIVISIT TREATMENT – If a crown, bridge, denture, partial or other prosthesis is to be fabricated by a dental laboratory, a 50% deposit is required at the time of the first impression. The remaining balance is due when the prosthesis is inserted.

EMERGENCY VISITS – Emergency patients who are new to the practice are expected to make payment at the time of treatment. Existing patients will be sent a statement for emergency care.

DELINQUENCY – Should an account balance be outstanding for 60-days, a $25 monthly fee will be applied and future care will be suspended until the account is paid in full.

COLLECTIONS – If a collection agency becomes involved in the settlement of your account, all collection costs and legal fees for both parties are the responsibility of the account holder.

I have read this form and fully understand my payment options and obligations. I further understand that the financial responsibility for services provided in this office for myself or my dependents is mine and due at the time services are rendered. I hereby authorize my insurance benefits to be paid directly to the dental office. I authorize the dental office staff to release any information required to receive claims. I understand that I am financially responsible for any balances due including cancellation and late fees where applicable. I have a right to copy of this notice and have either requested a copy or declined at this time. I reserve the right to request a copy in the future.

Signature _____ Date _____

Printed Names _____ Name of Minor _____

We realize that temporary financial situations may affect timely payment of your account. If such a problem should arise we encourage you to contact us before treatment for recommendations on the management of your account.

If you have questions regarding your account or to learn more about payment options including CareCredit please call our knowledgeable, experienced staff.

With our convenient payment options,

You can have the smile of your dreams today!