

FINANCIAL POLICY

Thank you for choosing Vivid Smile Dental as your dental health care provider. Vivid Smile Dental is committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. It is important that your account be handled properly in order to keep charges as low as possible. Your cooperation in this is appreciated. The following is a statement of Vivid Smile Dental's Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

VIVID SMILE DENTAL ACCEPTS CASH, CHECKS, OR CREDIT CARD

VIVID SMILE DENTAL OFFERS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL

It is the patient's responsibility to provide Vivid Smile Dental with up to date insurance information at the time of each visit. When information is given, Vivid Smile Dental may accept assignment of benefits; however, we do require that you pay any co-payment, deductible, and/or additional fees. This payment is required at the time of service unless prior arrangements have been made.

All charges are your responsibility. As a courtesy to you, we will submit claims to your insurance company and may accept assignment of benefits. If, however, your insurance company reduces the amount of, or denies the claim for any reason, the balance of the claim will be your responsibility.

Your insurance policy is a contract between you and your insurance company. Vivid Smile Dental is not a party to that contract.

Vivid Smile Dental may accept assignment of your insurance benefits but Vivid Smile Dental requires that you select an option for paying any remaining balance not covered by your insurance. Your options would include full payment with cash, check, credit card, or a pre-approved extended payment plan. If your insurance company has not paid your account in full within 60 days, the balance will be paid by the option you selected.

Please be aware that some services may not be covered by your insurance plan. This means that you are responsible for the bill.

Regarding insurance plans where we are a participating provider, all co-pays are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, you are responsible for full payment.

Assignment of Benefits

I request payment of insurance benefits to Vivid Smile Dental. I understand that I am financially responsible for all charges not covered by insurance. I acknowledge responsibility to provide Vivid Smile Dental with current patient information as well as current insurance information. I hereby authorize the release of any information necessary to process all claims.

Usual and Customary Rates

Vivid Smile Dental is committed to providing the best treatment for our patients and our charges are based on cost or what are usual and customary charges in the area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Collection Efforts and Fees

If a balance exists on your account past 90 days from the date of service, Vivid Smile Dental may transfer your account to a collection agency. This will be done at Vivid Smile Dental's option and any costs associated with the collection service will be added to your account.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan, or payment by cash, check, or credit card at the time of service has been received, in addition to required consent forms.

Missed Appointments

After your second missed appointment in any twelve month period, Vivid Smile Dental reserves the right to charge a \$25 Missed Appointment Fee. This fee is not normally covered by insurance and would be your responsibility. In order to avoid this charge any necessary cancellations must be made at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Print Name of Patient

Print Name of Parent or Guardian (if applicable)

Signature of Patient or Guardian

Date