Written Financial Policy

Thank you for choosing Dysart Dental. Our Primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, MasterCard, American Express or Discover Card.

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card **prior to completion of care for treatment plans of $500 or more.**

-NO INTEREST Payment Plans from Care Credit and Citi Health Card *[1]

- 6 Months Deferred Interest for charges $300 and above.
- 12 Months Deferred Interest for charges $1000 and above.
- 24, 36, 48 Months with Low Fixed Interest for charges $1000 and above.

Please note:

Dysart Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be available.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and bill them directly for reimbursement of treatment cost. *[2]

A fee of $25 is charged for patients who miss or cancel appointments without 24-hour notice.

Dysart Dental charges $25 for returned checks.

Service Charge- Unspecified collection fees may apply on past due accounts if not paid within 90days, after monthly billing period. I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I have read and understand that I am financially responsible.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need

Patient, Parent or Legal Guardian Signature Date

Print Name Patient Name (Please Print)

*[1] Subject to credit approval.
*[2] However, if we do not receive payment from your insurance carrier within 90days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Proper notice will be provided to you if we are having difficulty obtaining reimbursement