



M U R R A Y H I L L
D E N T A L

These financial guidelines are to inform you of the policies of our practice and provide you with excellent customer service.

Payment is due at the time services are rendered. As a courtesy, we will bill your insurance for you. We require that you pay the estimated copayment, which is the amount not covered by your insurance. After 60 days of non-payment from your insurance company you will be responsible for the entire balance due.

_____ (initial)

To help you pay for your dental treatment we accept the following:

- | | | |
|-------------|-----------------|-------------|
| -Cash | -Personal Check | -Visa |
| -Debit card | -Discover | -MasterCard |

Extended Interest Free payment plans are offered through Care Credit upon request and approval.

Returned checks to us from the bank for non-sufficient funds or closed accounts carry a \$30 service fee that will be added to your account in addition to the balance due for the treatment. _____ (initial)

Additionally, our practice may charge you \$75 for appointments that you do not keep and for appointments that are not canceled with 48 hour notice. We make every effort to stay on schedule and provide exclusive appointment times for our patients. Please help us by arriving on time to each appointment. _____ (initial)

Accounts past due 60 days or greater are subject to an 18% interest charge per annum. _____ (initial)

In the event of default of any payment obligations, our practice reserves the right to turn your account over to our Collection agency. _____ (initial)

With your signature and date below you show that you have read, understand and accept any and all of the above billing fees, interest and payment provisions. Please feel free to ask any questions that you may have, so that we may clarify any parts of our financial policy that you may not understand.

Patient Signature: _____

Date: _____