OralDynamics
Advanced Dental Esthetics

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FINANCIAL MENU

We offer the following financial options in order to pay for your dental treatment.

A. Pay as You Go
You may choose to pay your obligation for each visit with cash, check, or credit card at each visit.

B. Prepayment in Full
A prepayment bookkeeping courtesy of 5% will be given for direct payment in full of cash or check before or at the first appointment. (Does not apply to co-payments or deductibles)

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, Discover, American Express, Care Credit, Money Order, Personal Checks.

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 2% per month (or a minimum charge of $5 for a balance under $250) which is an annual percentage rate of 24% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs (35% of balance) and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

We do our best to estimate what you will owe, however, after your dental benefits have paid for the dental services rendered at Advanced Oral Dynamics, you may have an outstanding balance. This balance may include any deductibles, co-payments, denials, and non-covered services. For balances owed, we will require a credit card authorization. After each transaction your account receipt and the card transaction slip will be mailed to you at your address on file.

REQUIRED

I hereby authorize Oral Dynamics to process payments from time to time, as the office deems necessary, to settle my account in full. This agreement is considered valid until written notification is received.
I certify that I have read, fully understand, and accept the above financial policy
Responsible Party Name (Print): _____

Responsible Party Signature: _____ **Date:** _____

OPTIONAL

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit ☐ American Express

Card #: _____ Exp Date: _____ Not to exceed $_____

Card Holder Name (Print): _____

Card Holder Signature: _____

Billing Address: _____ State: ___ Zip: _____

Phone number: _____ Email: _____