Scottsdale FAMILY SMILES
MODERN DENTISTRY FOR THE WHOLE FAMILY

8055 N Via De Negocio, Scottsdale, AZ 85258
(480) 607-6937

FINANCIAL POLICY

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions or assist you in any way we can.

We happily accept cash, personal checks, or credit cards (Visa, Master card and Discover).

We also offer monthly payment plans through Care Credit. No interest plans up to 12 months and extended, low interest, payment plans up to 60 months are available.

There will be a $50 minimum charge for any broken appointment or appointment not cancelled or rescheduled with at least a **24 HOUR NOTICE.** The length of time scheduled for your appointment will determine the charge. The fee will be calculated based on a $100 charge for each hour reserved for you, the patient. All appointments planned for 1 ½ hours or longer will require a minimum deposit of $100 prior to scheduling.

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy without letting your insurance company dictate your care.

We cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance pays. In this instance we will bill you for the remaining amount due.

I,_____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all the charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time.

Patient (or responsible party) Signature:_____ Date: _____