Written Financial Policy

Thank you for choosing Belmont Dental Associates as your dental care provider. We are committed to providing you with the best dental care possible. 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 or Discover Card

  We offer a 8% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card three(3) business days prior to their scheduled appointment. This adjustment is only made on appointments for recommended treatment with the doctor.

- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Belmont Dental Associates, PC 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 patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

A fee of $36 is charged for patients who miss or cancel without 48-hour notice.

Belmont Dental Associates, PC charges $34 for returned checks. A late charge of 1 ½% will be added to any balance that is 60 days past due. This is an annual percentage rate of 18%.

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

I/We agree and personally guarantee, in consideration of services and materials provided by Belmont Dental Associates, to be responsible for payment in full of the dental bill. In the event that this matter is turned over to an attorney for collection, I/We agree that I/We shall pay twenty-five percent (25%) of the attorney's fees, interest on the unpaid balance at the rate of eighteen percent (18%) per annum and all costs.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval