FINANCIAL POLICY
Mitchell Dental Care, LLC

Mitchell Dental Care's goal is to help patients afford their dental treatment, while at the same time maintaining the high standards of comprehensive dental care that our patients deserve and expect.

We will provide our patients with good faith estimates of their total treatment costs prior to the beginning of their treatment. Patients should understand that the quoted fees for their treatment and insurance will only be *an estimate*. We will notify the patient immediately of any fee changes and obtain their approval prior to proceeding with treatment.

Payment is due in full at the time of service
We accept cash, personal checks, and credit or debit cards.

Young Adults and unaccompanied minors scheduled for non-emergency treatment will be seen if arrangements for payment with the person responsible for the Account are made prior to the appointment date and time.

Prepay Discount
We will extend a five percent (5%) reduction on estimated procedures totaling $3,000 or more if a patient ***prepays in full*** **for the treatment by cash or check** in advance of the treatment.

Dental Insurance
We strive to help our patients maximize their dental insurance benefits. While we are not an in-network provider, *as a courtesy*, we will electronically file your insurance claim within 24 hours of your appointment so that dental benefits may be paid directly to you.

Our office can also submit a preauthorization prior to treatment upon request so that you are advised of what your insurance will reimburse you for.

Patients should understand that their dental benefits are a contract between them, their employer, and their insurance carrier. Dental insurance plans are not designed to cover all dental needs. Rather, the amount of insurance reimbursement paid towards your dental care is based on the plan selected and purchased by you or your employer.

Payment Plan
For your convenience we offer a *payment plan* for patients who might otherwise forego needed comprehensive dental treatment. We will evaluate on a *case-by-case basis* whether a payment plan is indicated.

Returned Checks
A $25 fee will be charged for returned checks**.**

Cancelled/Broken Appointments
Appointments cancelled or broken within 48 business hours are subject to a $50 fee.

I, _____, accept full financial responsibility for this account and for all dentistry performed upon me and/or my dependents in this dental office. I also understand **payment is due in full at the time of service**. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits and that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate given to me by this office is not a guarantee of actual insurance payment.

Patient Signature: _____ Date: ____/_____/_____
(Responsible Party/Patient)

Revised 9/30/22