## Dr. Steven Fishbaine - Written Financial Policy 1/21/2019

Thank you for choosing our dental practice. Our primary mission is to deliver the best and most comprehensive dental care available. 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:

1. Cash, Check, Visa, MasterCard, American Express or Discover Card

\*\* To our fee for service patients (non-insured), we offer 5% cash or check courtesy for treatment of \$1000.00 or above due on the first visit of restorative treatment that requires a follow-up visit.

**\*\***Senior patients (65 years or older) who do not have insurance, can receive a 5% discount when paying with cash or check on the day of the service.

- **2.** A NO-INTEREST<sup>1</sup> Payment Plan<sup>2</sup> from CareCredit
  - Allows you to pay over 6 months with NO INTEREST<sup>1</sup>
  - $\circ$  A convenient, low monthly payment plan<sup>2</sup> available
  - No annual fees or pre-payment penalties

Please note: Drs. Fishbaine requires payment on the first day of your treatment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and submit insurance, as long as your insurance pays toward out of network dental services.

- For patients with dental insurance, the front desk will explain our procedure dependent upon our experience with the insurance plan. You or your employer has a contract with the insurance company. Dr. Fishbaine does not have a contract with any dental insurance plans. Therefore, you may be asked to pay in full on the day of your service, and any reimbursement will be sent to you by your insurance company.

A fee of \$50.00 is charged for patients who miss or cancel more than 2 times without 24-hour notice. There will be a \$30.00 charge for all returned checks.

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

Patient, Parent or Guardian Signature

## Patient, Name (Please Print)

Date

<sup>1</sup>If paid within the promotional period. Otherwise interest assessed from purchase date. Minimum monthly payment required. <sup>2</sup>Subject to credit approval.