Advanced Dental
Personalized & Comfortable

FINANCIAL OPTIONS

- **CASH OR CHECK**
  Receive a 5% bookkeeping courtesy by paying in full before, or at the time of service. For treatment requiring more than one appointment, the entire treatment plan must be paid in advance, or at the first visit in order to receive this 5% courtesy.

- **CREDIT/DEBIT**
  Receive rewards, miles or cash back from your credit card company by paying in full at the time of service. We accept all major credit cards including MasterCard, Visa, Discover, and American Express. Many of our clients prefer to pay with their credit cards as it allows them to maximize their existing rewards program.

- **DENTAL INSURANCE BENEFITS**
  Receive a bookkeeping courtesy when you pay in full at the time of service and allow your insurance company to process the claim and send the insurance benefit check directly to you. To help you maximize your benefits, we will complete and submit your insurance claim electronically for you. Once your insurance carrier has processed the claim, you will be reimbursed directly by them for any eligible benefits.
  ***NOTE: If you elect to assign your insurance benefits to our office, you must pay your estimated patient portion for your visit and leave a signed and valid credit card authorization form on file with us (complete the back of this form) which will be used to pay any remaining balance in the event your insurance company doesn't pay the expected, or estimated amount.*

- **IN-OFFICE SAVINGS PLAN** ~ typically for patients not covered by dental insurance
  We are happy to introduce and offer a unique and wonderful program to assist our patients without insurance - the Advanced Dental Savings Plan has been created just for you. For one low annual fee, you, your spouse and your dependents are eligible to receive a limited number of diagnostic, preventative and/or periodontal hygiene services each year and you will receive special pricing for all other treatments provided by our office. There are no claim forms to deal with; no pre-existing conditions, exclusions or limitations; no waiting periods; and no embarrassing questions in order to qualify. Ask one of our team members about enrolling in our Savings Plan today!

- **MONTHLY PAYMENTS**
  If you prefer to pay a little each month toward your dental care, we've made special arrangements with several, reputable third-party healthcare finance companies. This will allow you to complete your treatment and still be able to budget for affordable, monthly payments over time- many times with interest-free options and terms. One of our team members will be happy to discuss this payment option and current financing specials with you.
  ***NOTE: an administrative fee of 5% will be added to all financed treatment plans. (see terms and conditions of financing application).*

- **TREATMENT DEPOSITS**
  A 10% deposit is required for all Doctor Visits, as well as any appointments during evening & Saturday high demand appointment times. This deposit becomes non-refundable with less than 48 hours' notice of cancellation, missed or broken appointments, but may be transferred *one time* in the event of a last minute notification of a change in your schedule.

I understand my financial options and agree to one of the above arrangements. I understand any financial arrangement made to pay for my treatment outside of one of the options listed here will be discussed and decided on a case-by-case basis with management approval only and a valid credit card authorization form on file.

FINANCE CHARGE(S): If I do not pay the entire new balance of my account within 25 days of the billing date, a monthly finance charge will be assessed to my account for each current monthly billing period. The finance charge is currently a periodic rate of 1.5% per month, which is an APR of 18% applied to the last month's balance.

CREDIT CARD AUTHORIZATION ON FILE: I understand and agree that my credit card may be charged for any patient portion or account balance that is $50.00 or less and my responsibility after insurance benefit, and/or for any past due balance that remains unpaid by either me or my insurance carrier after 60 days.
In the case of default of payment, I promise to pay all accrued finance charges, interest, and administrative fees on the balance due, together with any collection costs and attorney's fees incurred in order to collect on this account.

SIGNATURE: _____ DATE: _____

Advanced Dental of New England, LLC
39 Webster Square Road • Berlin, Connecticut 06037
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Advanced Dental of Cromwell, LLC
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AUTHORIZATION FOR CREDIT CARD PAYMENTS
(CREDIT CARD ON FILE)

I, _____, understand that I have chosen to assign my dental benefits to **Advanced Dental** and claim form(s) will be sent to my insurance company for treatment provided and/or I am entering into a financial arrangement with the office to pay for my dental treatment.

I further realize that I am ultimately responsible for the cost of treatment regardless of my insurance company's willingness to pay a benefit. I hereby authorize **Advanced Dental** to keep my signature on file and to charge my credit card account for any and all treatment fees not paid by my insurance carrier or myself within 60 days or in agreement with the terms/dates of my financial arrangement.

***NOTE: We will make every effort possible to notify you in advance of your authorized card being charged for an amount greater than $100.00.*

_____
Cardholder's Address 1

_____
Cardholder's Address2

_____
Cardholder's Telephone #

❑ MasterCard ❑ Visa ❑ AMEX ❑ Discover

_____
Credit Card Account #

_____/_____ _____
Exp Date CVV2

_____ _____
Cardholder's Signature Date

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