EAST COOPER DENTAL EXCELLENCE
FINANCIAL POLICY

Payment in full the day of service is appreciated. Your estimated co-payment must also be paid the day of service. We gladly accept Visa, Mastercard, American Express, Discover, CareCredit, cash or check. Any balances over 90 days will be considered in default and the entire balance shall be deemed to be immediately due and payable. Upon default the amount due may be turned over to an attorney for collection. I agree to pay all costs of collection including attorney fees. A 50% DEPOSIT IS DUE FOR PROCEDURES OF $500 OR MORE AT TIME AN APPOINTMENT IS SCHEDULED. If the appointment is cancelled less than 24 hours of appointment date, 25% of your deposit is retained as a cancellation fee.

We are happy to help you by filing your dental claim, at no charge to you the day of service. When two dental benefit plans are involved, we will file the primary and the patient is responsible for their portion. The secondary plan will also be filed by our office for benefits to be paid to the patient It is however your responsibility to follow up with your dental company to assure prompt payment in order to avoid late payment due to mishandled claims. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

I hereby authorize payment directly to East Cooper Dental Excellence of the dental benefits otherwise payable to me. Furthermore, I authorize East Cooper Dental Excellence to provide my dental company's claim administrators and consulting health care professional, information concerning my health care, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract in force on this date, or for two years, whichever is shorter, unless revoked by me. I have received a copy of this authorization and agree that the photographic copy of this authorization is as valid as the original.

If there appears to be a problem with payment of your dental benefits, or you have unexpected difficulty in meeting your financial obligation with our office, please let us know as soon as you suspect that there is a problem. Early communication between you and our office manager can often allow benefit problems to be alleviated prior to the 90 day deadline, and may also allow us to help you meet your obligation without action outside this office.

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Patient or Authorized Person's Signature Date

There is a $25.00 fee for all returned checks. For broken appointments without 24 hour notice there is also a $50.00 fee.