Smiles On Trindle Dental Care
5229 E Trindle Road | MECHANICSBURG PA, 17050 | (717) 697-4606

Written Financial Policy

Thank you for choosing Smiles on Trindle Dental Care. Our primary mission is to provide the most professional and comprehensive dental care available. An important part of the mission is making the cost of treatment manageable for our patients by offering several payment options.

Payment Options:

- Cash, Check, Visa, Discover, MasterCard, Health Savings, Care Credit, Online Bill Pay (available 03/01/17)
  - *For uninsured patients we offer a 5% courtesy adjustment for services rendered and paid for in full day of service.*
  - *For non-covered procedures or uninsured patients receiving treatment in excess of $1000; we offer a 10% discount to those that are able to pre-pay in full prior to their dental visit. A 5% discount is offered if paid in full day of service.*
- Monthly Payment Plan options are available through the office or Care Credit
  (No courtesy can be offered if payment plan is necessary)
  - *In-house Payment Plan Options – Tele check, Half/Half (patient portion paid by delivery date)*
  - *Care Credit * – 6 or 12 month deferred interest plan options, no annual fees or pre-pay penalties*

Please Note:

Smiles on Trindle Dental Care requires payment in full by the final service date of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with in-network dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. *

Additional In Office Charges:

- *$30 – No show/less than 24 hour notice for all cancelled appointments with our hygienists*
- *$50 – No show/less than 24 hour notice for all cancelled appointments with our doctors*
- *$35 – Returned check fee*

Account statements will occur weekly with a 15 day remittance period. All accounts over 90 days past due will be considered for collections.

- *In the event that any portion of the invoice remains unpaid and subsequently submitted to collections, I understand that I will be additionally responsible for the collections fee of 25%*

Should you have any questions regarding this financial agreement, please speak with one of our financial coordinators for clarification or concerns.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) DOB

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.