FINANCIAL POLICY

Welcome to our practice. We are committed to making this an enjoyable and rewarding journey. We look forward to providing you with the smile that you have always dreamed of having. A great smile is an investment for a lifetime and we want to make your experience as affordable as possible.

METHODS OF PAYMENT

We do accept insurance assignment, but the patient portion is due by separate arrangement. Monthly billing can be accomplished through a variety of options.

Method	When	Terms
Check/cash	At time of service	$25 returned check charge to cover bank fees
Debit card	Direct debit 1st or 15th	0% from us for treatment duration; no fees Paperless, automated billing
Credit Card Visa, Discover MasterCard	Direct debit 1st or 15th	0% from us for treatment duration; no fees Interest per your credit card agreement Paperless, automated billing
3rd Party Healthcare Financing Options		
https://secure.springstoneplan.com/ Springstone Finance	Beginning of treatment	Fixed rates as low as 3.99% for 24 to 84 months No down payment option
http://www.carecredit.com/ CareCredit Finance	Beginning of treatment	14.9% for 24 to 60 months No down payment option

We accept all dental insurance as an out-of-network provider. We participate in TriCare Dental, Delta Dental, MetLife, Cigna, Assurant and Humana plans. When you provide us with your insurance policy numbers we will be able to estimate the amount of your insurance benefit. The remainder not covered by insurance may be financed by one of the above options. The estimation of insurance benefits from your company is that – only an estimate based on current information. Ultimately the billing party is responsible for payment of all fees for orthodontic care rendered by our office. You will be provided an all inclusive fee that covers diagnosis, placement of braces, routine adjustments, retention and 2-years of retainer monitoring. The treatment fee quoted is for the total treatment and each payment is not tied to that particular month's service. The number of months of treatment time may be shorter or longer than the payment schedule depending on down payment, payment plan and treatment progress. Transfer out patients will be credited with any fees paid in advance of treatment progress.

I have read and understand the financial policy of **Bentele Orthodontics.**

_____ _____/_____/201__
Signature of Patient, Parent or Guardian Date

INSURANCE AUTHORIZATION – SIGNATURE ON FILE

I hereby authorize Bentele Orthodontics, PC to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize payment of healthcare benefits otherwise payable to me, directly to Bentele Orthodontics. I agree to be held responsible for all charges and services not paid by my insurance company. Valid only for orthodontic treatment by this office.

_____ _____/_____/201__ _____
Signature of Patient, Parent or Guardian Date Witnessed By

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