



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 of benefit 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 separately by arrangement. Monthly billing can be accomplished through a variety of options.

Method	When	Terms
Check/cash/card	At time of service	5% discount if full fee paid at beginning of treatment
Debit card	Direct from your account monthly	0% from us for up to 20 months; no fees Paperless, automated billing
Credit Card Visa, Discover MasterCard	Direct from your account monthly	0% from us for up to 20 months; no fees Interest per your credit card agreement Paperless, automated billing
CareCredit	Beginning of treatment	11.9% for 24 to 60 months No down payment option
Capital One	Beginning of treatment	Varies depending on individual credit: 1.99%-23.99% for up to 60 months No down payment option

We accept all dental insurance as an out-of-network provider. We also participate in United Concordia, Delta Premier and Teamster plans. When you provide us with your Insurance Policy Numbers we will be able to estimate the amount of your insurance benefit. There are diagnostic records fees which are credited toward the initial fee of \$1500 for case workup and placement of braces. The remainder not covered by insurance may be financed by one of the above options. We do our best to accurately estimate your insurance benefits, but ultimately you are responsible for payment of all fees for orthodontic care rendered by our office. There is a \$25 returned check charge to cover the bank fee.

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

Signature of Patient, Parent or Guardian

Date

INSURANCE AUTHORIZATION – SIGNATURE ON FILE

I hereby authorize Bentele Orthodontics 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.

Signature of Patient, Parent or Guardian

_____/_____/200_____
Date

Witnessed By

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