

Written Financial Policy

Thank you for choosing IvyRose Family Dentistry PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of \$1000.00 or more.

- Convenient Monthly Payment Plans¹ from CareCredit

- o Allow you to pay over time
- o No annual fees or pre-payment penalties

Please note:

We will file your insurance as a courtesy to you, but we do expect your estimated payment and necessary deductible to be paid at the time of service. The estimated co-payment is merely an estimate and not a guarantee of payment by your insurance company. You must provide name, address and phone number of your insurance company in order for us to submit a claim form. If not provided, you will be required to pay for your visit in full and your insurance company will reimburse you. After 60 days any unpaid balance becomes your responsibility and is subject to collection process. We charge 3% interest on all past due accounts.

IvyRose Family Dentistry PA requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Cancellations/No Show Appointments:

Please remember to contact our office at least 24 business hours prior to your appointment time. A fee of \$50.00 will be assessed to your account for all appointments cancelled without the 24 hour notice.

IvyRose Family Dentistry PA charges \$30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval