Morning Glory Dental
Financial Policy
Effective January 1st, 2015

Payment Methods Accepted:
Cash, Check, Visa, MasterCard, Discover, CareCredit, and Springstone.

Missed Appointments:
Please understand that we reserve chair time just for you when you make an appointment with us. Please be respectful and give our office at least 24 hours' notice if you need to change your appointment. Failure to do so may result in a $50 missed appointment fee. Multiple failed/cancelled appointments will result in dismissal as a patient of record._____ (Initial)

Patients with dental benefits:
It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Please remember the dental insurance is a contract between you and your insurance provider. Our office will gladly submit your insurance claim to your insurance carrier. We prefer when possible to preauthorize treatment to prevent surprises for you and our office. We will do our best to work with your benefits but remember that if for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. _____ (Initial)

Patients without Dental Insurance:
We offer a 10% discount on fees if paid on the day of service. We encourage you take advantage of this discount. _____ (Initial)

Balances beyond 90 Days:
Monthly payments are expected on all accounts. If a balance is not paid in full within 90 days from the date of service, a monthly interest charge of 1.33% or 16% annually will be applied. _____ (Initial)

Financing:
We accept both CareCredit and Springstone. These are both 3rd party financing companies available for application on line. Both offer interest-free options for up to 24 months dependent on dollar amount and credit rating. All accounts that cannot be paid within 90 days are encouraged to apply and transfer balances. _____ (Initial)

Collections:
In the unfortunate event that an account has no payment made in a 90 day period, the account will be referred to a collection agency for further collection action. Families of accounts sent to a collection agency will be dismissed and not rescheduled with the practice. _____ (Initial)

I have read and understand the above financial policies. It is understood that this executed copy of the Financial Policy will also cover my dependent children who are patients of the practice. I authorize release of any information pertain to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X_____ _____
(Patient or Parent or Guardian signature) (Date)

X_____ _____
(Printed Signature) (Date)