ben pyatt dental
buffalo prairie dental

# FINANCIAL AGREEMENT

## EFFECTIVE JANUARY 1, 2018

OUR MISSION IS TO DELIVER THE FINEST DENTAL CARE AVAILABLE TODAY. FINE DENTISTRY IS TRULY AN INVESTMENT. OUR GOAL IS TO HELP YOU MAKE THIS INVESTMENT POSSIBLE.

PAYMENTS FOR TODAY'S VISIT AND YOUR FUTURE VISITS ARE DUE AT THE TIME OF SERVICE. WE ARE SENSITIVE TO THE FACT THAT SOME PEOPLE MAY NOT BE ABLE TO PAY CASH FOR THEIR TREATMENT; THEREFORE, WE OFFER SEVERAL ALTERNATIVE PAYMENT PROGRAMS, THERE ARE DELAYED INTEREST AND LOW INTEREST OPTIONS AVAILABLE TO YOU. FOR THOSE WHO ENJOY DENTAL INSURANCE BENEFITS, WE ASK YOU TO PAY THE ESTIMATED PATIENT PORTION AT THE TIME OF SERVICE.

WE NOW OFFER THE FOLLOWING PAYMENT OPTIONS:

1. BEN PYATT DENTAL PATIENT LOYALTY PROGRAM
2. CASH, CHECK OR CREDIT CARD
3. CARE CREDIT
4. 5% REDUCTION ON AMOUNTS OVER $1000.00 IF PAID IN FULL AT THE TIME OF SCHEDULING FIRST APPOINTMENT FOR TREATMENT.

ANY APPOINTMENT SCHEDULED 2 HOURS OR MORE MAY REQUIRE A 20% DOWN PAYMENT TO HOLD YOUR RESERVATION.

IF AN APPOINTMENT IS SCHEDULED OUTSIDE NORMAL BUSINESS HOURS 50% DOWN PAYMENT WILL BE REQUIRED.

WE MAKE YOUR HYGIENE APPOINMENTS 6 MONTHS AHEAD, SO THAT WE CAN ACCOMMODATE YOUR DESIRED DAY AND TIME.

DUE TO OUR HIGH VOLUME OF PATIENTS AND THE QUALITY OF CARE WE PROVIDE TO EACH PATIENT, WE ENCOURGE YOU TO KEEP THAT APPOINMENT IF AT ALL POSSIBLE.

IF YOU SHOULD NEED TO CANCEL YOUR APPOINMENT, WE ASK THAT YOU GIVE A 24 HOUR NOTICE. IF 24 HOUR NOTICE IS NOT GIVEN AND/OR YOU FAIL YOUR APPOINTMENT A $35.00 FEE MAY BE APPLIED TO YOUR ACCOUNT.

PLEASE REMEMBER INSURANCE IS A CONTRACT BENEFIT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE HAPPY TO ASSIST YOU IN BILLING YOUR INSURANCE COMPANY AND MAXIMIZING YOUR BENEFITS. HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR THE COST OF TREATMENT PERFORMED. WE HAVE PROVIDED A PLAN FOR YOU TO ENHANCE YOUR HEALTH AND WELLNESS AND WE ARE COMMITTED TO EXCEPTIONAL CARE.

IN THE EVENT THAT YOU SHOULD DEFAULT ON AN OVERDUE BALANCE YOUR ACCOUNT WILL BE SENT TO A COLLECTION AGENCY. YOU WILL THEN BE RESPONSIBLE FOR ANY COLLECTION COSTS, ATTORNEY FEES OR COURT COSTS.

IF YOU HAVE ANY QUESTIONS PLEASE ASK ANY OF OUR TEAM MEMBERS.

DATE: _____

PRINT NAME OF PATIENT: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____