South Pointe Dental

Seth Spangler D.D.S
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Financial Agreement

Thank you for choosing South Pointe Dental for your dental needs. We are committed to providing you with excellent care. We believe payment of your bill is part of successful treatment. Our financial policy is based on an open and honest discussion of our fees. Please read, sign, and return the following.

Payment in full is due at the time of service. We offer several options of payment for your convenience:

1. We accept cash, VISA, MasterCard, Discover Card, American Express, and personal checks.
2. We offer payment plans through Care Credit. If you are interested in applying for payments please see the office manager**. All financial arrangements must be made prior to treatment.**

Insurance Benefit

As a service to our patients, we will bill your insurance company; however your co-payment or percentage of the bill is expected at the time service is provided. All co payments are based upon estimates only. In the event that your insurance company pays less than expected you are responsible for the difference. You are also responsible for any claims unpaid after 90 days or more by your insurance company. In the event that your insurance company pays, we will refund the amount to you. We cannot render services on the assumption that the charges will be paid in full by an insurance company. I authorize to release financially identifiable information and treatment descriptions and information to my insurance carrier or any related entities that require such information.

Minors

Payment for treatment of minors is the responsibility of the adult accompanying the minor at the time of service.

Emergency Visits

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are rendered.

Missed Appointments

There will be a $40 charge per hour for any missed appointments or cancelled appointments with less than a 24 hour notice.

Service Charges

It is our policy to charge interest of 1.5% per month or 18%APR which will be applied to all accounts that are 60 days past due. There will be a $50 charge for any returned checks.

Collection Fees

Fees incurred to collect payment will be billed to, and payable by the patient in addition to reasonable attorney fees and court costs where such legal services are necessary equal to 50% of the outstanding balance.

I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charged, to the collection agency should it become necessary.

Financial Consent

The patient (or guardian) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy. This agreement supersedes all prior agreements signed, including any and all mediations or mediation/arbitration agreements. I acknowledge that any prior signed agreement is null and void.