FINANCIAL POLICY AND PAYMENT OPTIONS

At Redwood Family Dentistry, we expect a full payment of your estimated patient portion at time of service. For treatment over $2,000, a deposit fee is required at the time of scheduling; the remaining balance is due at the time of service. If the patient cancels seven (7) or more business days before the procedure, a full refund of the deposit will be given. If procedure is rescheduled seven (7) or more business days before, the deposit will be forwarded toward the fees of the new procedure date. If the procedure is canceled or rescheduled less than seven (7) days in advance, the deposit will be forwarded toward processing fees and becomes non-refundable. It is vital you give our office a 48-hour notice to avoid a canceled appointment charge of $100.

Being sensitive to different needs to our patients, we offer the following flexible payment options:
• We accept payment in cash, checks, money orders, debit or credit card (MC, Visa, American Express, and Discover).
• We offer **CARE CREDIT 0% INTEREST FREE and EXTENDED** payment plans for patients' copay amount with pre-approved application from a responsible party.

At Redwood Family Dentistry, we accept most dental insurance:
• As a courtesy to you, we will file claims on your behalf. It is the patient's responsibility to provide us with current insurance information. If any payment from an insurance company becomes 30 days past due, you will be billed for the entire balance.
• Not all services are covered by insurance. In the event you insurance plan determines a service to be "not covered" or "denied" you will be responsible for the complete charge. Our staff can never guarantee your eligibility and coverage. Insurance limitations and regulations vary with all insurance plans.
• We will file pre-treatment estimates at your request only. Filing a pre-treatment estimate is usually not recommended as it will likely result in delaying the treatment.
Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. There will be a $35 service charge for a returned check.

If you have any questions regarding our financial policy, please feel free to ask any of us in the office. We are committed to providing you with the most positive experience in dental care.

I have read and understand the above Financial Policies and Payment Options.

Patient's Name: ______________________ Signature: _______________________ Date: ___________

Dr. Salek
60783

Doctor's Signature: _______________________________________ Date: ________________