SOUTHWEST FAMILY DENTISTRY

389 SW Chapel Hill Street
Lake City, FL 32025
386-752-1220

OUR FINANCIAL POLICY

Welcome to our office! We are honored that you have chosen us as your dental care provider and we look forward to working with you. Our dental practice team is committed to providing an excellent dental care experience to you and your family. We have implemented the financial policies outlined below to assist in that regard. This enables us to focus on what we do best- providing you with personalized, excellent comprehensive dental care services.

We offer more than one payment option. Therefore please read and select the option that best suits your financial preference.

[ ] 1) We offer a 4% discount for whole treatment plans prepaid no later than 48 hours prior to appointment.

[ ] 2) We offer pay as you go option, which means you are responsible for services rendered at that appointment. This option can be paid by cash, check or credit or debit card. Please make sure you know what your estimated out of pocket will be.

[ ] 3) We offer a payment option that allows you to pay for your services over 12 months at no interest with Care Credit. (WITH APPROVED CREDIT)

We strive to keep the cost of your dental care down while delivering the finest care. Fees quoted for services will remain in effect for 1 year as long as treatment has commenced within 3 months, otherwise prices are subject to change. Sometimes clinical conditions warrant a modification in treatment. You will be notified of any changes in treatment and/or fees prior to proceeding with the modified treatment plan.

DENTAL INSURANCE IS FILED AS A COURTESY TO OUR PATIENTS. ESTIMATES ARE MADE OF THE PATIENTS COPAYMENT AT THE TIME OF TREATMENT, BUT WE DO NOT GUARANTEE EXACTLY WHAT YOUR INSURANCE COMPANY WILL PAY. FULL PAYMENT FOR SERVICES PROVIDED IS ULTIMATELY THE PATIENT'S RESPONSIBILITY.

Please indicate your understanding and acceptance of these financial policies by signing below. If you have any questions please let our staff know. This also covers any dependent children who are patients in our practice. Thank you.

Signature and Date ----------