

MIDWAY SQUARE DENTAL CENTER  
**Financial Options**

Our Mission is to deliver the finest, most cost effective health care treatment available at a fair value. Once the doctor has advised you of your diagnosis and the plan of treatment, the cost of treatment will be discussed with you. Payment for today's visit and your future visits are due in full at the time of services. We do offer several alternative payment programs for your convenience.

*Please designate your choice by placing an X in the square.*

**CASH, CHECK, OR DEBIT CARD**

**MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS**

We accept these major credit cards for your convenience. Enjoy the payment flexibility of charging all your treatment with your credit card.

**LINE OF CREDIT MONTHLY PAYMENT PLAN**

For those patients who prefer to pay a little each month, we've made arrangements with a financing company to finance your dental work with approved credit. This will allow you to complete your dental work without delay. This does not affect your balances of other credit cards. There are no annual fees, interest free for 90 days if paid within 90 days. Application forms are available at the reception desk.

**DENTAL INSURANCE BENEFIT**

Your dental treatment may be covered by your dental insurance policy. By presenting your insurance card and to help you in maximizing your benefits, we'll gladly assist in filling out and submitting your insurance claim forms. By assigning your insurance benefits to the doctor, we will estimate the amount not covered by your insurance carrier and that amount will be due at the time of service. If the carrier does not cover any of the estimated amounts, you will be financially responsible to pay within 30 days or preferably with an approved credit card number on file.

**INSURANCE COMPANY** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**GROUP/POLICY#** \_\_\_\_\_

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I, \_\_\_\_\_, understand Midway Square Dental Center's financial policies and agree to the above arrangements. If I do not pay the entire new balance within 30 days of the billing date, a late charge will be added to the account for the current monthly billing period. In, addition, I also understand that I am financially responsible for all charges not covered by my insurance.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

For office use only

Receipt     Line of Credit Application     Credit Card     Dental Insurance/Credit Card