ZOMA DENTAL

FAMILY AND COSMETIC DENTISTRY

Financial Policy

Insurance:

As a courtesy, we will submit insurance claims on our patient's behalf. It is your responsibility to understand your insurance benefits. We will do the best we can to estimate your portion prior to your dental treatment, but you are responsible for all balances not covered by your insurance. Our practice has a contractual obligation with your insurance company to collect payments at the time of service. The amount may be subject to adjustment when the dental service claim is paid by an insurance company. In addition, most insurance companies have annual maximums and the patient is responsible for monitoring and paying for any services that exceed those maximums. If the insurance company pays the patient instead of Zoma Dental, the patient becomes fully responsible for the total account balance for the services provided and payment is expected immediately.

Missed or Cancellation Fees and Deposits:

- We understand that circumstances arise, and appointments may need to be changed. However, we value our patients and their dental health, and we ask that you do the same. Therefore, if you miss or cancel your appointment without a 24-hour notice, a cancellation or no show fee may be applied. This fee will be based on the type of appointment that is reserved for you.
- Due to the extensive amount of time our staff and Doctors devote to preparing and reserving the time for longer appointments, we may require a deposit of half down when scheduling certain procedures.

Payment Options:

- Cash
- Personal Check
- Credit Card (Visa, Mastercard, Discover, American Express)
- Healthcare Financing (CareCredit or Lending Point)

Care Credit/Lending Point:

If financial arrangements are needed, we will be happy to help you. Both Care Credit and Lending Point are great options and offer customized plans. Both offer extended plans with no finance charges and have no prepayment penalties. Or you may choose to pay over longer periods of time with interest charges. Requires approval based on credit, income, and valid ID.

I have read and accept the practice's financial policy. I understand that I am responsible for any charges incurred from services rendered.

Patient Name: _____ Date: _____

Patient Signature: _____