CRISTEL
FAMILY DENTISTRY

The Financial Policy of Our Office

Thank you for choosing the team at Cristel Family Dentistry as your dental care provider. We understand that dental treatment may involve an investment of time and money for you and your family. We offer multiple payment options including cash, check, Visa/MC/Amer Exp, or Care Credit to pay for your dental treatment.

We are happy to offer a 10% (7% credit card) courtesy discount for all treatment PAID IN FULL at the time of service with exclusion of Care Credit.

Monthly payment arrangements through Care Credit, (deferred interest installment loan) are available upon approval. If you would like more information about Care Credit please ask. Approvals usually take just 15 minutes.

Statements are sent our by the 5th day of the month, specifying what services were charged, the amount billed to your dental plan (if applicable) and your total balance due. A finance charge of 1.5% per month are automatically assessed to your entire existing balance at 60 days from the date of service.

DENTAL INSURANCE

For the convenience of our patients that are utilizing their dental plan we will submit all claims for treatment. We want to remind you, that all patients are fully responsible for payment of accounts and that we do not render services on the basis that insurance companies will pay any and all fees. As a courtesy to our patients, we try our very best to give an estimate of what your insurance company may pay for services from information we receive over the phone, but in no way are we responsible for or ever guarantee payment from an insurance company.

CANCELLATION & MISSED APPOINTMENTS

In order to ensure you and other patients received uninterrupted treatment, it is necessary for patients to adhere to all scheduled appointments. Once we have scheduled your appointment time, please remember that this time is reserved for you. We ask that you make your very best effort to notify our office at your earliest possible time if an appointment change is necessary. There will be a $50.00 charge for any failed appointments if notification is not given within 24 hours of your schedule time. There is a $35.00 office charge for returned checks.

Please Initial _____ I have read, understand and agree to the above office policies.

I hereby authorize direct payment of my dental benefits otherwise payable to me, directly to Cristel Family Dentistry or Ripp Cristel, DDS.

Signature: _____ Date: _____