Montpelier Family Dentistry

14502 Greenview Drive, Suite100 Laurel, MD 20708 (301)604-0025

Written Financial Policy

Thank you for choosing Montpelier Family Dentistry for your dental services. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Debit card, Visa, MasterCard, Discover

After the patient has come in for an initial visit and a comprehensive treatment plan has been presented, we offer a 5% courtesy discount to patients who prepay for their **entire** treatment plan in full with cash or check. (**Discount does not apply to any insurance plans or any third party financing- ex: Care Credit, Lending Club, etc).**

- NO INTEREST Payment Plans thru: Care Credit, Spring Stone
  - Allow you to pay overtime with NO INTEREST
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

Please note:

Montpelier Family Dentistry **requires payment prior to scheduling for your treatment**. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. (Note what is estimated by your insurance to be covered is **ONLY** an **ESTIMATE**). **Services which are NOT COVERED will be the responsibility of the patient.**

A fee of $45.00 is charged for patients who miss or cancel appointments without 48- hour notice.

If an outstanding balance/bill is not paid within 30 calendar days, a finance charge will be applied.

Montpelier Family Dentistry **charges $35.00 for returned checks.**

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

For any future scheduled appointment, a deposit/copayment is required to ensure that the time and space is reserved for you.

I have read the above policy and agree to accept ALL financial responsibility

Patient, Parent or Guardian Signature _____ Date _____

Patient Name (please Print) _____