Pro Solutions Dental Group
FAMILY, IMPLANT, & RECONSTRUCTIVE DENTISTRY

Payment Policy

www.PrescottDentist.com

Thank you for taking the time to understand our Payment Policy. For any questions about fees, financial policies, or your responsibilities, please contact our front office staff.

PAYMENT OPTIONS
For convenience, we accept cash, check, Discover, MasterCard and Visa. Check payments require a valid photo ID. Acceptable ID include a state or military ID.

For convenience, financing options are available through CareCredit® patient payment plans, providing:

- Flexible financing options
- Convenient low minimum monthly payments
- No annual fees or prepayment penalties
- Immediate credit decision

CareCredit® can be an excellent financial solution for your care needs. Restrictions may apply. Our team is available to assist you with CareCredit's® online application and approval process.

PAYMENT FOR MINORS
The attending adult bringing a child for treatment is responsible for payment at time of service. A divorce decree does not supersede our policy for payment. Our billing system does not accommodate billing two separate parent accounts for payment.

PATIENTS WITH DENTAL INSURANCE
We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance is to be paid at the time of service.
Having a secondary insurance does not guarantee that services will be covered 100%. Your dental insurance plan is a contract between you, your employer, and the insurance company. It is the patient's responsibility to understand the provisions, benefits and restrictions of the policy.

Please notify our office of any changes in insurance company, policy number, or coverage. To keep your information current, and will assist in prompt insurance payments. Also, advise our front office of any insurance claims that have incurred prior to visiting our office as these claims may affect your estimated amount owed, and remaining coverage.

As a courtesy, our office will file all applicable insurance forms. Please note that our front office will calculate as closely as possible the difference estimated to be your responsibility. Although we strive to provide an accurate estimate of your portion due, such information is NOT a guarantee of payment or eligibility with your insurance company and is ONLY an estimate. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. Reduction or rejection of your claim by insurance does not relieve you of financial obligation with our practice.

Payment for co-payments, non-covered services and deductibles' are due at time of service any balance due after your claim has been settled.
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RETURNED CHECKS
Personal checks that are returned due to “insufficient funds” are turned over to the Yavapai Country Attorney’s office. If not paid upon notification, the account(s) will be turned over to collections and charged a $25.00 service fee per account. Appointments for care will be suspended until account(s) is in good standing.

SERVICE CHARGE
Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00), equivalent to an annual percentage rate of 18% applied to the last month’s balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. **Please be advised that there is a $40.00 fee charged for missed or broken reservations without 24 hours’ notice. To avoid this charge, kindly give us a minimum of 24 hours’ notice for any appointment cancellation.**
Feel free to contact us at any time with questions you may have.

Authorization
I have read and understand the above Payment Policy. I hereby authorize payment directly to Jason C. Campbell DDS PLLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient’s dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grand the right to Jason C. Campbell DDS PLLC to release the patient’s dental and/or medical histories and other information about the patient’s dental treatment to third-party payers and/or other health professionals

_____ _____
FIRST NAME LAST NAME

_____ _____/_____/_____
SIGNATURE DATE