uSmile Dental Centers

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Financial Policy

Thank you for choosing uSmile Dental Centers. 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, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] Insurance companies state that they will cover a percentage of their fee schedule, and we do our best to estimate your portion.

There will be a $5.00 fee for Universal Precautions / Biomedical Waste with every visit, in addition to your office visit co-pay. This fee cannot be billed to your insurance. Additional charges may be applied for upgraded laboratory materials as needed per patient care.

A fee of $40 is charged for patients who miss or cancel an appointment without 24-hour notice.

X-ray Policies:

With some insurance policies, the frequency and limitations of radiographs can range from once every 36 to 60 months. In order to give you the best quality of care, if you are a new patient and do not bring current radiographs, new x-rays will be taken. It is the patient's responsibility for payment of these x-rays at the time of service if past the frequency limitations of your insurance coverage. Also, in order to properly diagnose certain pathologies, systemic manifestations of metastatic bone cancers, cystic lesions, carotid plaques, impacted/super numerary teeth, degenerative joint disease of TMJ, etc. a panoramic radiograph x-ray (D0330) will be taken. A full mouth series of x-rays is also performed (D0210), which is not usually covered with a panoramic radiograph, **which makes the panoramic x-ray the patient's responsibility**. This amount will be collected on the date of service. **This is applicable with most PPO insurance** policies. Also, we are more than willing to provide any patient copies of their current or previous radiographs. We can provide these to the patient via e-mail or the patient can pick up copies. **There will be a $15 handling fee collected prior to x-rays being given to the patient as a processing fee.**

I, _____, authorize Dr. Friend or any doctor working in the office to perform diagnostic testing, take radiographs, use anesthetics, prescribing of medication, and perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

If you have any questions, please do not hesitate to ask.

I have read and agree to the office policies of uSmile Dental Centers and acknowledge receipt that I have read a copy of uSmile Dental Centers Notice of Privacy Practices.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier you will be responsible for payment of your treatment fees.