Norwalk Family Dentistry
Dr. Donna Grant
Dr. Maureen Winslow
Financial Responsibility

Dental treatment is an excellent investment in an individual's health and well being. Because of this, we believe financial considerations should not be an obstacle to obtaining this procedure. **PAYMENT AT TIME OF SERVICE IS EXPECTED**. In situations involving large treatment plans and/or insurance benefits, we provide 2 payment options. **We do not offer in-office financing**. We are sensitive to the fact that different patients have different needs so the following are the financial options available to our patients.

CASH, CHECK or CREDIT CARDS

We accept cash, personal and certified checks as well as VISA, MasterCard, Discover, American Express, and Debit Cards at time of service.

LOW MONTHLY PAYMENT PLAN

Our office currently uses an outside financing agency-CareCredit. These are specifically designed for dental and related specialties – with low monthly payments. (Subject to Approval)

- CareCredit-interest free 6-12 month (subject to approval)
- No prepayment penalty, terms up to 12 months
- Quick and easy application process. Same day approval!

INSURANCE COVERAGE

Our practice will be happy to assist you in determining whether your insurance company will cover your dental services. If your company does provide a benefit, our administrative team will be happy to assist in filing your claim. After your initial visit and diagnosis of treatment, our administrative team will discuss with you what benefits your insurance company provides. Patients are responsible for any portion not covered by insurance and those amounts are due at time of service.

DENTAL INSURANCE PATIENTS:

I understand my dental insurance is a contract between myself and the insurance carrier, not between Norwalk Family Dentistry and your insurance carrier. As such, I understand that I am responsible for the full amount of all dental fees incurred. Any payments received by Norwalk Family Dentistry from my insurance carrier will be credited to my account or refunded to me IF I have paid the dental fees incurred.

I understand that the payment of my bill is my legal obligation as the patient**. This office applies interest charges at the rate of 9.9%APR to accounts over 90 days**. **I further agree to pay returned check charges of $25.00 per returned check.** If this account is placed in the hands of an outside collection agency, I agree to pay the fees incurred by that agency in regards to the collection process.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE