Cleveland Dental Associates
Financial Policy/Informed Consent

Thank you for choosing Cleveland Dental Associates as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
Cash, Check, Debit, Visa, MasterCard, Discover, American Express are accepted methods of payment. Personal checks will be electronically debited from your bank account on date of service. Outside financing is also available through Capital One, Care Credit and Citi-Health Financial. Financial arrangements other than the accepted methods are to be discussed with a Financial Officer prior to your visit as approval is required *before* treatment.

Adult patients are responsible for full payment of deposit requirements at the time of service. The adult accompanying a minor child is also responsible for same. Any non-emergency treatment will be denied unless payment can be made as described above on the date of service. There is a $25.00 charge for Returned Checks, and balances over 60 days are subject to a $5.50 late fee. IC Systems is the entity that handles accounts after they fall into the 60 day or over category for collections. You will be responsible for all fees, including court costs, should it be necessary to refer your balance to those agencies. A charge of $50.00 may be made for broken appointments and cancellations without proper notice of 24 hours. A **$100.00 non-refundable deposit** may be required for appointments of 90 minutes or longer, with a **48 hour minimum notice for cancellation**, in order to be able to offer all our patients their most preferred appointment times. Broken appointment fees are enforced to encourage patient attention to reserved time and in an effort to minimize fee increases. Non-compliance with recommended treatment and excessive broken appointments may be subject to dismissal.

Thank you for your understanding and cooperation. Please let us know if you have questions or concerns.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status.
I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis. I also authorize the doctor (and his/her employees when applicable) to perform any and all forms or treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made.

I have read, understand and agree to this Financial Policy and Informed Consent. I have been given an opportunity to discuss questions or concerns with an officer.

_____ _____
Signature of Responsible Party Date