BAY COSMETIC DENTISTRY
JEFFREY V. SCHROEDER, D.D.S.
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FINANCIAL POLICY & SERVICES AGREEMENT

1. **Introduction.** Our payment options have been designed to provide you, our valued patients, with a high degree of flexibility and assistance while enabling us to control the associated administrative costs. This approach makes us partners In the effort to maintain fees at a level that is equitable to all parties. If you need any assistance with financial matters relating to your dental care, the front office staff is happy to assist you with your needs.
2. **Payment Options.** Clients are required to pay at the time services are rendered. For your convenience we accept the following payment methods: cash, in-state checks, Visa, MasterCard, Discover, American Express, and debit cards. Care Credit, a payment plan, is also available in our office.
3. **Dental Insurance.** If you have insurance must notify us prior to receiving services. As a courtesy, we accept assignment of insurance benefits but only if we are able to verify current coverage and have received a copy of your insurance card. We will estimate your insurance benefits and your portion of the fee is to be paid at each visit. You are responsible for any portion of your bill that your insurance company does not cover. If for any reason your insurance company rejects a claim or pays less than what was estimated, the remaining balance must be paid immediately.
4. **Unpaid Accounts and Collections.** You agree to pay all invoices, statements, and demands upon presentment. Unpaid balances will accrue interest of 5% per month or the maximum permitted by law. If we must refer your account to a collection company, you will be charged a collection fee of $200 or 20% of the outstanding balance, whichever is greater. If we must sue to enforce this agreement or if we must bring or defend any other action, suit, arbitration, or other proceeding brought by or against you, we will be entitled to our reasonable attorney's fees and costs, including fees and costs for collection of judgements if we are the prevailing party.
5. **Dispute Resolution.** You agree that If you dispute any invoice, charge, or statement, you shall contact us in writing within 30 days of the claim and identify the item, charge, or other matter in dispute and your reason for such dispute. In the event of a dispute, lawsuit, or other legal proceeding, such matters will be subject to the laws of Florida and must be filed in Hillsborough Pinellas County, Florida.

Accepted by the Patient:

Signature of patient (or parent/guardian if minor)	Date
Patient Printed Name	Patient Social Security Number
Patient's complete street address (no post office boxes)	
Patient date of birth	Patient's phone number
Emergency contact name & phone number	

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