CAROLINA
SMILE DESIGN

SUBMIT FORM

1721 Ebenezer Rd, Suite 105
Rock Hill, SC 29732
803-327-6453
Fax 877-255-3252

Patient Financial Agreement

Thank you for choosing Carolina Smile Design. Your smile is yours forever and our goal is to assist you in every way possible in receiving the best dental care.

Our practice accepts most major credit cards and insurance plans.

Payment is expected in full for each appointment as services are rendered. If you have a traditional insurance plan we can assist you by filing your insurance claim. We ask that you pay for non-covered expenses at the time of service.

Please keep in mind that your dental insurance is based on a contract between you and your insurance company. **We make every effort to estimate your dental benefits to the best of our ability, however this is an estimate only. Any unpaid balance remaining after insurance pays is your responsibility.**

We want to make the cost of optimal dental care manageable by offering the following payment options:

- Cash
- Check
- Most major credit cards
- **Care Credit**

Through **Care Credit** you can receive "no interest" financing or low minimum monthly payment options. For more information you can visit **carecredit.com**. After approval, you are free to use **Care Credit** for many services including dentistry, LASIK, veterinary, hearing aids and more. We accept the 6 month interest free option and the low minimum monthly payment options in our office.

If you need to cancel an appointment, please make every effort to let us know 48 hours in advance. A fee of $50 may be assessed for not cancelling 48 hours prior to your appointment. Patients who miss or cancel more than 3 appointments in a calendar year without 48-hour notice may be dismissed from the practice.

A 1.5% late fee will be charged per month or a minimum late charge of $30.00 will be added to unpaid balances over 45 days past due. After 90 days from the time of service if there has been no communication and attempt to pay balances they will be sent to collections.

A fee of $50 will be charged for returned checks.

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

By signing this document I am stating that I understand and agree to the **Patient Financial Agreement**.

Patient, Parent or Legal Guardian Signature Date

Patient Name (please print)