Infinity Dental Arts
Discover your smile

Financial Policy

Here at **Infinity Dental Arts**, our doctors are dedicated to providing our patients with the best in dental services. Our primary goal is to not allow the cost of treatment to prevent you from benefiting from the care you need or desire. And although we are aware that in this society, healthcare is insurance driven, we do not work for your insurance company, we work for you.

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

- Payment is due at the time services are provided. We accept MasterCard, Visa, Discover, American Express, cash and personal checks (for established patient only). Outside financing is also available upon request and approval of all treatment over $1,000. Please direct any questions to our Financial Coordinator. We also offer a 10% discount to our noninsured patients on services over $600 if paid in full with CASH. We do not offer a traditional in office payment plan; however, we can offer to break up payment of your treatment plan evenly over the course of the treatment.

- **Please Note**: In the event a check is returned, the check will be returned to you, and you will be charged a fee of $50. This fee covers processing fees charged to our office.

Do you have Dental Insurance?

In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

As a courtesy to you, we will gladly file all insurance claims on your behalf. Please understand that we will provide an insurance estimation to you however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequencies, age restrictions, deductibles and maximums. It is your responsibility to contact your insurance for a detail of its benefits. We will do all we can to ensure your estimation is as accurate as possible. Your estimate insurance benefit may differ due to reasons specifically related to your plan.

All balances unpaid by your insurance company are your responsibility. We expect payment within the initial 30 days, any balances unpaid after 30 days will incur $35 Monthly late Fee. After 90 days all balances will be turned over to our collections agency, where additional late fees will incur. We encourage you to contact us promptly for questions or concerns pertaining to your account.

Please Note: It is your responsibility to inform our front desk of any changes to your contact information, address or dental insurance coverage before services are rendered.

Our staff is also knowledgeable when it comes to flex accounts, open enrollment, and HSA accounts. We are trained to help you maximize your benefits and resources to obtain great oral health. Please feel free to direct any questions to our financial coordinator.

Thank you for understanding our Financial Policy. Our dentists' only concern is getting you back to healthy and happy smile. They are not privileged to insurance information or the terms of your policy. Please divert all financial and insurance questions to our experts at the front desk.

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Deposit Policy

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for you; we require a deposit for any major treatment prior to scheduling.

Missed Appointments/Rescheduling/Cancellation Policy

Our practice is dedicated to quality care and exceptional service. Our goal is to provide treatment in a timely manner with a few visits as necessary. Our doctors and team spend extensive amount of time preparing for your visit. In order to provide the best services to our patients, we require a minimum of 48 hours' notice of any changes needed to your appointments. This allows us to make every effort to accommodate other clients. A charge of $25 may be assessed for missed appointments, short notice, or cancellations. 3 failed appointments may result in being dismissed as a patient.

Consent:

I have read, understand and agree to the above terms and conditions. I also authorize my insurance company to pay my dental benefits directly to my dental office.

By signing below, you are authorizing us to call you at any number you provide for any lawful purpose. You understand we may call you in regards to your account or account balance in attempt to collect any outstanding debt.

In consideration for the professional services rendered to me _____, by Dr. Diaz or Dr. Ramos. I agree to all that is stated above.

For all minors: As a parent or legal guardian accompanying a minor, whom has consented to treatment, I understand I am responsible for all terms and conditions stated in this financial policy.

Signature: _____ Date: _____

If minor: Name of responsible party_____

Relationship to patient _____