MAPLEWOOD DENTAL ARTS
providing a lifetime of healthy smiles

Financial Agreement

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Thank you for choosing Maplewood Dental Arts for your dental needs. We appreciate the confidence you have placed in us. Our primary mission is to provide you with the highest quality of care, in the safest possible environment.

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

Our fees reflect our commitment to the quality of care that our patients deserve. We will be happy to answer any questions regarding treatment costs and, if requested, will provide you with the paperwork to send to the insurance company for a pre-treatment estimate of costs prior to any treatment beginning. Please understand that fees may be altered if dental needs change.

We do not accept assignment of benefits for insurance. Because of this we require payment at time of service for any treatment done at our office. If you have insurance, we will send you home with completed paperwork for you to send to the insurance company to be reimbursed for the services. For those patients without dental insurance, we offer a membership plan for a one-time yearly fee or a low monthly fee that will include routine care* and will give an additional discount on anything not included in that fee, with the exception of products. We also accept American Express, Master Card, Visa and Discover, and are pleased to offer no interest1 payment plans through CareCredit and Lending Club with no annual fees or pre-payment penalties. In addition to this, anything over $500.00 may qualify for an in-house payment plan with office manager approval.

Failure to pay in accordance with the above will result in a monthly late fee not to exceed 18% per year or 1.5% per month and/or dismissal from the practice.

A fee of $100.00 will be charged for patients who miss or cancel their appointment without 24 hours' notice. Excessive failed or 'no show' appointments may lead to dismissal from the practice. Please help us to serve you better by keeping scheduled appointments.

If you have any questions please do not hesitate to inquire. We are committed to providing you a lifetime of optimum oral health.

Signature required _____Print name_____Date _____
(patient, parent or other responsible party)

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1. Subject to credit approval. Must be paid within promotional period. Minimum monthly payment is required.

* Please see membership plan pamphlet or ask one of our patient care coordinators for details.