BRANDON A. JAMES DDS
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# Office Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy. In order that we may have a definite understanding regarding the payment of dental fees, these are the available options:

**Dental Insurance:** If you have dental insurance please allow us to make a photocopy for our records. Most plans will cover only a part of the usual charges for even the simplest procedures. We will complete and process your dental insurance form stating services and charges rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that this individual is personally responsible for payment of dental services.

**Payments Due:** Payment options for multiple treatment procedures are: 1.) One half due at the first appointment and one half at completion; or 2.) One third of the total fee is due at the first appointment, one third of the fee is due at the second appointment, and the balance is payable at completion of treatment. We offer 5% discount if paid in cash at the first appointment.

**Visa/Master Card/Discover:** Visa / Master Card / Discover Card debit/credit and checks.

**Extended Payments:** You are welcome to make your own personal arrangements with the lending institution of your choice. We are also pleased to offer Care Credit. CareCredit can be reached at http://www.carecredit.com or 800-365-8295. Through CareCredit both Doctors offer up to one year interest free financing. Extended terms are available if qualified up to a term of 60 months. Please feel free to ask for a brochure and information at the front office.

If there are any special needs or circumstances please feel free to discuss with the Doctor or front office personnel. Occasionally, unforeseen situations do arise which may prevent a patient from making a payment prearranged on a given day. In the event of difficulty with a pre-arranged payment we ask that patients please contact our office to avoid the possibility of a misunderstanding.

By signing below you acknowledge full responsibility for the payment of all necessary services at the completion of treatment. Your signature authorizes your insurance carrier to pay the dental benefits of your plan directly to us and lets us release any information to your insurance carrier that is necessary to process your dental insurance claim.

**SIGNATURE REQUIRED BEFORE SERVICES ARE RENDERED**

| | | | |
|---|---|---|---|
| Patient: | _____ | Resp. Party: | _____ |
| Address: | _____ | Phone: | _____ |
| Phone: | _____ | Signature: | _____ |
| E-Mail: | _____ | Date: | _____ |