FINANCIAL GUIDELINES

THE CENTER
FOR COSMETIC DENTISTRY

Dedicated to

Aesthetic, Comfortable

and Comprehensive

Dental Care.

We at ***The Center For Cosmetic and Family Dentistry*** are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your healthcare investment, we provide the following payment options:

Payment Options

- **Cash --Includes money orders, certified checks, and personal checks**
- **Visa/MasterCard/Discover/American Express/Debit cards accepted for payment**
- Easy Payment Options—**A monthly payment plan that we offer as a separate line of credit to cover you and your family member's healthcare needs. Approval usually takes only a few minutes and you can apply confidentially at our office.**
  - No Interest Options up to 12 Months!
  - Low interest extended payment plans up to 60 Months
  - No pre-payment penalties or annual fees are charged.

If the easy payment plan is your preferred option, you can begin any necessary treatment immediately and spread the payments out over time. **Please let our Financial Coordinator know if you have any questions about this information.**

As a courtesy to you, we will be glad to accept your primary insurance benefits. Your co-payments are due at time of service. **If we are accepting assignment of your insurance, we require a credit card to be kept on file for any remaining balances not paid within 45 days.** If you have secondary insurance, we will gladly file all claims to be paid to you for reimbursement

Which option do you choose?

□ **Cash/Check** □ **Extended payment plan (or Interest free)**
□ **Credit/Debit Card** **Individual Financial Information Required**
□ **Insurance with Secured Account (see below)**

Credit Card (Bank/Debit Card): _____ Exp Date _____

Cardholder Name _____ **Phone Number** _____

Acct # _____ **#on Back** _____

Cardholder Address_____**City**_____**State**____ **Zip** _____

I authorize the office of Gregory B. Raymond, D.D.S. to keep my signature on file for this year and to charge credit/debit card after calling me, for unpaid balance within 45 days. I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to *The Center for Cosmetic & Family Dentistry*, Gregory B. Raymond, D.D.S., F.A.G.D.

Cardholder/Guarantor Signature_____**Date** _____