ANNETTE C. THEOFILOS, D.M.D.

Thank you for choosing ACT Dental Inc. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Please read all information and acknowledge by signing

You can choose from:

- Cash, Check, Visa or Mastercard
- A 2% fee will be added for credit card payments
- Convenient Monthly Payment Plans from CareCredit®(allow you to pay over 6 months) No annual fees or prepayment penalties*

Please note:

ACT Dental Inc. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and will bill directly for reimbursement for your treatment. **It is ultimately your responsibility to ensure that you check that we are contracted with your insurance, whether or not certain procedures are covered, at what percentage and for annual maximum totals.**

Coinsurance is due once claim payment has been received. We will endeavor to determine this information but as the contract is between you and the carrier it's ultimately your responsibility. **

A fee of $25 is charged for patients who miss or cancel more than 1 time in a calendar year without 24 hour notice. Messages left over the weekend/or after hours when we are not in the office may not constitute the required 24 hours. If 3 appointments are missed you will be dismissed from the practice for non-compliance.

If insurance denied charges or doesn't pay in a timely manner or if account is delinquent (60 days) we reserve the right to refer your account to a collection agency to be reported to the credit bureau. A 1.5% finance charge will be added monthly to any balance over 60 days. ACT Dental Inc. charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need. Please remember whether you have insurance or not, you are ultimately financially responsible for payment of your charges.

I have read and have a full understanding of the financial policy of Dr. Annette Theofilos.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

*Subject to credit approval

**However if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.