



Sangiv I Patel DDS PA

501 N Harbor City Blvd | MELBOURNE FL, 32935 | (321) 254-4613
www.drspatel.com

Written Financial Policy

Thank you for choosing Sangiv I Patel DDS PA. 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.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to beginning of care.

- NO INTEREST¹ Payment Plans² from CareCredit or Chase Healthcare Financing.

- o Allow you to pay over time with NO INTEREST¹
- o Convenient, low monthly payment plans² also available
- o No annual fees or pre-payment penalties

Please note:

Sangiv I Patel DDS PA requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$500 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³

A fee of \$100 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Sangiv I Patel DDS PA charges \$30 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.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)



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Patient Payment Agreement

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

The estimated cost for your treatment is \$_____. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. _____

(Patient initials)

As you know, it is this practice's policy to receive payment prior to beginning of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. It is estimated that your insurance will cover \$_____. You have agreed to pay your patient portion of the treatment fee in the following way:

- Payment in full in the amount of \$_____
 - Paid with: _____
- Deposit required: \$_____
 - Deposit paid with: _____
 - Remaining treatment fee: \$_____
- To be paid by: _____ with _____
- Payments for Each Phase of your treatment plan separately

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

We look forward to seeing you at your scheduled appointment at _____ on _____.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.