LARRY B. GRILLO, DDS
JOEL C. GALE, DMD
AND ASSOCIATES

AVENTURA DENTAL ARTS, LLC

FINE ESTHETIC, IMPLANT AND RESTORATIVE DENTISTRY

FINANCIAL OPTIONS

Our commitment is to provide quality dental care for the entire family through exceptional service and the utilization of advanced technology

METHODS OF PAYMENT

1. Cash
2. Check
3. Debit Card
4. Credit Card (MasterCard, Visa, Discover and American Express)
5. Healthcare finance (application available) or any 3rd party financing
6. Dental Insurance (described below)

CHOICES OF PAYMENT

1. Pay As You Go:
For simple procedures or routine maintenance, payment is due on the day of treatment.

2. **Prepay Courtesy 6% (for fees over $10,000):
For those wishing to decrease the overall cost of care, a prepayment courtesy of **6%** is available when the total ***Estimated Treatment Plan** is paid in full by cash, check or money order on or before the first treatment visit (5% courtesy is available for payment in full via credit card).

3. **Courtesy for Two Payments 4% (for long term treatment only):
*A 4% courtesy is available when the total patient obligation is divided as follows: **50%** due prior to the **first treatment visit**, with the **remaining balance**, to be scheduled in **advance** of the completion of treatment.*
***Note:** Balance payments may be written at the initiation of treatment and "post-dated" for the prearranged date.*
Our guarantee: If a post-dated payment is deposited prior to the date on the face of the check (or credit card slip) we will **credit your account** for an **amount equal and in addition to that payment.**

4. ***Healthcare finance (for fees over $2,500):
With fast approval over the phone from selected healthcare financial institutions, you can have lower payments and spread them over a longer period of time. These companies specialize exclusively in helping patients with larger dental cases to do the treatment they want. We will assist you in contacting them from our office.

** We will make every effort to have the initial **estimated treatment plan** as accurate as possible however during the course of treatment some **variations may occur.** Some of the planned procedures may not be required, resulting in a refund to you, or there may be additional unanticipated procedures needed. In the event that actual treatment changes from the estimated treatment plan you will be advised at that time and the overall fee will be adjusted accordingly. (For those electing to receive the **prepay courtesy** the same courtesy will apply to any of these additional charges.)*

***Not applicable for reduced fee dental plans*

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INSURANCE

It is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. ***We will need you to bring us a copy of your benefit booklet if you would like help in interpreting your benefits****. If your carrier is up to date (in over 90% of the cases), the claims will be transmitted via computer modem before the end of the treatment day. Your estimated co-payment is expected at the time of service****. Please remember that this is only an estimate based on the information available to us.*** *After insurance reconciliation any overpayment on your part will be credited or refunded to you and any unpaid balance will be due by you upon receipt of our statement.*

The range of benefits varies from policy to policy. *Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range.*

Some plans base the amount of benefits on a schedule of fees arbitrarily developed by insurance companies referred to as a UCR fee schedule. For this reason, you may receive a lower ***percentage*** *than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means* ***no more than 80% of the fee arbitrarily determined by the insurance company*** *and may not be the actual fee charged by our office.*

The ***financial obligation for dental treatment is between you and our office****. The insurance company is* ***responsible to you****, and* ***not to our office****. We will assist you in any way that we can. Once your carrier has paid the claim, any difference will be due by you upon receipt of our statement. If for any reason, we have* ***not received*** *your* ***insurance*** *carrier's payment* ***90 days*** *after the claim, the* ***remaining balance*** *will be due and* ***payable by you****, and subject to 18% APR.*

RELATED FINANCIAL INFORMATION

- *Returned checks and balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.*
- *In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).*
- *In the event you are unable to keep your scheduled appointment, we request that you give us 24 hour notice. After 2 missed appointments we reserve the right to request pre-payment prior to scheduling your next appointment.*

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

*Name (Please print):*_____

*Signature:*_____

*Date:*_____

Authorized signatory for Aventura Dental Arts, L.L.C.

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