CALVERTON DENTAL CARE
Gregory V. Keating, D.M.D.
General Dentistry

Dear Patient

We want to take this opportunity to express our appreciation for your support and patronage. Our goal is to provide you with quality care at a reasonable fee. In order to serve you better, we have instituted the following policies to allow our staff to concentrate more fully on patient care.

At the time of service payment is due in full. If insurance is utilized, the estimated amount that is the patients' responsibility is due in full. Any balance remaining after the insurance has processed is the patients' responsibility.

You can choose any of the following payment options:

- Visa, MasterCard, Discover, cash, or check

We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $500 or more.

- NO INTEREST[1] payment plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

I understand that it is my responsibility to call my insurance company if I have any questions concerning my benefits prior to my appointment.

All accounts that are past due after 90 days will be assessed a service charge of 8% annually. Additionally, all past due accounts are subject to collection and include all collection costs and/or attorney fees. You are agreeing to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts.

A minimum of 24 hours' notice is required for appointment cancellations or changes to avoid a broken appointment charge of $10.00 per 15 minutes. Confirmations calls are done as a courtesy only. You are still responsible for your appointments.

I agree to the above policies and I give permission to process and release necessary insurance information to include the assignment of benefits to my dental office.

NAME _____

SIGNATURE _____ DATE_____

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2] Subject to credit approval.