Vista Family Dentistry Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you and your family with comprehensive dental care using current techniques and high quality materials. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage.

Although our practice is able to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. It is important you understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company.

Insurance payments are typically received within 30-60 business days from the time of billing. Any remaining balance after your insurance has settled a claim and/or paid is your responsibility. If your insurance company has not made a payment to our practice within 60 days, we will ask you to pay the balance and you will be responsible for seeking reimbursement from your insurance company.

Although we can provide an estimate upon request, our practice does not guarantee your insurance company will assist with payment for your treatment. If your claim is denied, you will be responsible for paying the balance in full (please see payment options below). Please note that we will submit any and all necessary documentation your insurance company requests but we will not enter into a dispute with your insurance company over any claim. It is your responsibility to resolve any type of dispute with your insurance company.

Vista Family Dentistry Payment Information:
We will send you a monthly statement.
We accept Cash, Check, Visa, Discover, MasterCard, and American Express.
We offer a 10% Senior Discount to patients (not their family members) at age 65 and older.
We request that patients without dental insurance be prepared to pay at the time of service.
We accept CareCredit. CareCredit offers third party deferred interest financing options upon approval. For more information or to apply, visit www.carecredit.com.

Please note if your balance is not paid in full, interest rates may apply

If none of these are an option for you, please see a member of our office staff and they may be able to assist you with another option or a payment plan.

Patient Name: _____ Date: _____

Patient Signature (or parent/guardian): _____