COMPTON DENTAL CENTER FINANCIAL GUIDELINES

We are committed to your treatment being successful. Please understand that payment of your account is part of your treatment. We will always seek to inform you of all fees involved in your treatment and to get permission before any treatment is done. The following section outlines our Financial Guidelines. Please feel free to ask our Financial Manager any and all questions you might have.

OPTION #1 - **Cash or Personal check.** We offer a cash courtesy of 5% (10% for those patients 65 or older)for all payments received before or on the day the treatment is rendered.

OPTION #2 - **MasterCard, Visa, Discover or American Express** charge cards.

Option #3 - **Financing.** We have teamed with Care Credit (outside financing) as well as offer In-house financing thru PME which can offer affordable monthly payments. Our Financial Manager will gladly help you determine how either of these could work for you and will help you make prior arrangements before any treatment is begun.

Insurance is a benefit, which helps to defray the cost of your dental treatment. To avoid any misunderstanding, we wish you, the patient, to know that all professional fees rendered are charged directly to you. You are personally responsible for the entire payment of those fees. We will gladly help you by filing your insurance claim, and directing the payment to come to you.

INSURANCE RELEASE:
I authorize Compton Dental Center to release any information, including the diagnosis and the records of any treatment or examination rendered to me and/or my minor child during the period of such dental care, to third party payors and/or health practitioners. I understand my insurance payment will come directly to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

_____ for _____ Date _____
Signature patient

Account agreement:
I have had all my questions answered and agree to Compton Dental Center's Financial Guidelines. In the event that this account becomes delinquent, I agree to pay a finance charge of 1.5% per month or 18% annually. Further if the undersigned patient or responsible parties' account becomes delinquent, the undersigned will pay all legal fees or other costs incurred by our office in the collection of this account.

_____ Date _____
Signature