

Dr. Landon Cansler DMD PLLC
430 West 20th Street
Newton, NC 28658

Financial Policy

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Payment Options

1. We request payment by cash, check, Visa, MasterCard or Discover on the day you receive treatment.
2. For treatment involving lab fees (crowns, bridges, dentures), you may choose to pay 50% on the preparation date and the balance on the delivery date.
3. For extensive treatment, you may prefer to obtain 3rd party financing for the entire amount and make payments to the financial institution. We offer special financing through Care Credit. If you pay them within 6 months, there is no interest charge.
4. If you have insurance, we will accept your deductible and out-of-pocket portion on the day you receive treatment. We will file your insurance as a courtesy to you.

Insurance

Insurance is a contract between you and the insurance company. Although we will "estimate" what may be paid, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If the insurance company will only issue a check to you, you agree to pay the charges on the date of service, unless other arrangements are made in advance. Your signature on this agreement is the signature on file for insurance claims we file on your behalf.

Statements and Finance Charges

If you have a balance on your account, we will send you a statement. The balance on your statement is due and payable when the statement is issued, and is past due if not paid within 28 days, unless we approve other arrangements.

A finance charge may be imposed on charges that have not been paid within 60 days. The **FINANCE CHARGE** will be computed at the rate of 1% per month, or an **ANNUAL PERCENTAGE RATE** of 12%.

Past Due Accounts

If your account becomes past due, we will take necessary steps to collect this debt. If this account is submitted to a collection agency or an attorney, or is litigated in court, the fact that you received treatment in our office may become a matter of public record.

Patient's name _____

Responsible party (if not the patient) _____

Signature _____ Date _____

Name of another person we can talk with about your account, if you desire:

Name _____ Relationship _____