BIOSMILE, Inc.
165 NW 1st St.
John Day, OR 97845
(541) 575-0363

Financial Policy

We feel that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

Please check the box that applies to you;

"I have No dental insurance"

- ❑ I would like to pay by cash, check, or debit card at the time of service.
- ❑ I would like to pay by credit card at the time of service.
- ❑ I would like to pay by CASH, not check, in full, at time of service and receive a 5% discount.

"I have dental insurance"

- ❑ I would like to pay my estimated portion by cash, check, or debit card at the time of service.
- ❑ I would like to pay my estimated portion by credit card at the time of service.

1. On treatment involving laboratory fees (crowns, bridges, dentures, etc.), we require 50% of the total fee paid on the preparation date and the balance on the delivery date.

2. Patients with insurance. As a courtesy, our office will compile and submit all the necessary information to your insurance carrier. You are expected to pay your deductible and any out-of-pocket portions at the time of service. We will accept benefits for the remaining balance. In the event your insurance company overpays we will refund you promptly. If your insurance company does not make payments within 60 days, you will be notified. If payment is not received within 90 days, you are immediately responsible for the remaining balance. If provided with the proper information we will also bill secondary carriers for you.

3. Finance Charge: If an account, which is the patient responsibility, is not paid in full within 30 days a 1.5% service charge will be added to the account balance per month.

4. Returned Checks: There is a fee of $25 for any check returned by the bank.
   For your convenience, we accept cash, personal checks, Visa, MasterCard, and Discover.

I have read and agree to the above financial policy.

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Signature of Patient Print Patient Name Date