Financial Responsibility

Stradley Hagerty LLC

Dental treatment is an excellent investment in an individual's health and wellbeing. Because of this, we believe financial considerations should not be an obstacle to obtaining treatment in a timely manner. Therefore, we provide the following financial options to our patients.

CASH, CHECKS, OR CREDIT CARDS

We accept cash, personal and certified checks as well as Visa, Master Card, American Express, Discover, debit and/or health saving cards.

MONTHLY PAYMENT PLANS

Our office currently uses an outside financing agency. Care Credit is specifically designed for dentistry and related specialties. (Subject to Approval)

- **Interest free option available for $200.00 and up with 6 months same as cash offer**
- No initial payment
- No prepayment penalty
- Quick and easy application process. Same day approval!

INSURANCE COVERAGE

Our practice will be happy to assist you in determining whether your insurance company will cover dental services. If needed, a pre-treatment estimate will be sent to your insurance company to determine benefits. As a COURTESY, our office will file your claim(s). **PATIENTS ARE RESPONSIBLE FOR ALL DEDUCTIBLES AND CO-PAYMENTS AS SERVICES ARE RENDERED. PLEASE BE AWARE THIS IS ONLY AN ESTIMATE NOT A GUARANTEE OF INSURANCE PAYMENT.** I authorize the release of information requested by my insurance company for the purpose of insurance payment. I authorize payment directly to Stradley Hagerty LLC. A copy of this authorization shall be valid as the original. Insurance payments not received withing 60 days will become your responsibility.

RESPONSIBILITY FOR PAYMENT

As a patient or parent/guardian who requests treatment, I understand, **I am fully responsible for total payment of services performed on the day services are rendered.** This includes any amounts not covered by my dental insurance. Parent(s)/guardian who initiate treatment for a minor child are primarily responsible for payment and any charges that may occur. By signing this Financial Responsibility Form I agree to pay a finance charge for any balance that remains unpaid for more than 90 days. A $5.00 minimum charge or 1.5% (18% annually) will acquire each month for unpaid balances. Items pending insurance will not be charged interest. I agree to pay all court costs and attorney fees incurred in collecting any amounts which are in default as well as the interest outlined above. $25.00 will be charged for any returned checks. I understand that payment of my bill is my legal responsibility, and if this account is placed in the hands of an outside collection agency, I agree to pay any fees incurred by that agency.

Patient/Guardian Signature_____ Date_____