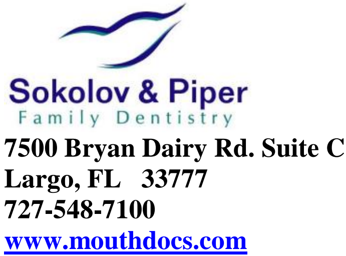

7500 Bryan Dairy Rd. Suite C
Largo, FL 33777
727-548-7100
www.mouthdocs.com

Written Financial Policy & Payment Options

Thank you for choosing Sokolov & Piper Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients by offing several payment options.

Please understand that treatment cost will only be an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment.

Please take a moment to review the financial options offered.

- Cash, Check, Visa, MasterCard, American Express or Discover
- Convenient Monthly Payment Plans from Care Credit (subject to credit approval)

As a courtesy, for patients with dental insurance we are happy to bill your dental insurance to maximize your benefits for reimbursement for your treatment, **you are responsible for your estimated co-payment at time of service.**

Please note:

Sokolov & Piper PA require payment at the time of your treatment. For treatment plans requiring multiple appointments, alternative payment arrangements may be provided. Please contact our financial coordinator if you have questions regarding the payment options. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I, ______________________________, accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to know my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I understand that any insurance claim not paid in full after 90 days will become my responsibility to pay at that time. I also agree to be responsible for the payment of all services rendered on my behalf or my dependents, and agree to any additional fees that may occur in the collection of my account.

SCHEDULING APPOINTMENTS

Due to the time reserved with the Dentist or Hygienist for your appointment we require a deposit of $100.00 or 25% of the cost of your services, whichever is greater. If appointment must be rescheduled or cancelled a 48 business hour notice must be given. If insufficient notice is not given to reschedule or cancel your appointment this will result in forfeiture of all deposits.

Some appointments do not require a deposit, but patient will be charged a missed appointment fee of $100.00 if 48 business hour notice is not given. We do understand that circumstances do arise and we will take this into consideration at time of appointment.

____

Patient, Parent or Guardian Signature Date

Patient Name (Please Print) ____