HARVEY M LEVIN
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WE ALWAYS GIVE 100%

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# STATEMENT OF FINANCIAL RESPONSIBILITY AND PAYMENT ARRANGEMENTS

Thank you for allowing us to take care of your dental needs. Please review the following office policies relating to this "statement of financial responsibility and payment arrangements" and sign below to acknowledge your understanding and acceptance of these agreements.

I, _____ (patient/guardian) understand that:

1. Dental treatment rendered to _____ (patient) is the sole responsibility of _____ (patient/guardian).
2. Payment is due at the time treatment is rendered.
3. We accept cash, checks, Visa, MasterCard, Discover and American Express.
4. Returned checks are subject to a $45 returned check fee.
5. A dental benefit plan is a contract between the patient/guardian and their plan. Our professional services are rendered and charged to you, not your benefit plan. Your benefit plan may pay all or a portion of the fees charged to you. Full payment is your responsibility. Accordingly, we encourage you to be fully aware of the provisions of your particular plan. If it is important for you to know the amount of your reimbursement, we will submit a pre-treatment estimate. This pre-treatment estimate is not a guarantee of payment; it is merely an estimate of benefits.
6. We will provide you with the necessary information and paperwork so that you may be reimbursed from your plan as promptly as possible.
7. For dental treatment over $5000 the following payment options are available and can be arranged, in advance, with our finance manager.
   a. Three equal payments.
      - First payment, at the start of treatment,
      - Second payment, thirty days later,
      - Third payment, thirty days later.
   b. Pay 1/3 of the estimated cost of treatment at the start of treatment. The remaining balance is to be paid in equal monthly payments over the course of treatment.
8. Are you a member of a dental benefit plan? ☐ YES ☐ NO
   (DO YOU HAVE DENTAL INSURANCE)

Employer _____
Name of plan _____
ID# _____
Group# _____

X_____ _____
Signature of patient/guardian Date