MASSEY FAMILY DENTISTRY

C. Benjamin Massey, DMD
6801 Fairview Rd, Suite B 28210
704-366-2568

Financial Arrangement

At Massey Family Dentistry, we are committed to providing you exceptional dental care and comfort. We will ensure you understand any necessary treatment and associated fees.

We offer several convenient and flexible payment options. Payment is due at the time of service.

Option 1: Payment in full at the time of service (cash, check, Visa, Mastercard, Discover)

Option 2: Payment of all insurance co-payments and deductible at the time of service. This dental office will submit the dental benefit claim on the behalf of the patient given the patient (or parent/guardian) agrees by signing below that:

- Dental benefits submitted are only estimates. The patient (or parent/guardian) agrees to be responsible for all charges for dental service and materials not paid by the dental benefit plan, unless prohibited by law, or the treating dentist/dental practice has a contractual agreement with the plan prohibiting all or a portion of such charges.
- This dental office will follow-up on any unpaid dental insurance benefits for 90 days. If the office has not received a payment from insurance after 90 days, then payment is immediately due from the patient (or parent/guardian).
- To the extent permitted by law, the patient (or parent/guardian) consents to the use and disclosure of patient's protected health information to carry out payment activity in connection with claims.
- The patient (or parent/guardian) hereby authorizes direct payment of the dental benefits otherwise payable to him/her, directly to the above named dentist/dental entity.

Option 3: In office savings plan – payment directly to the dental practice for a period of three months in advance of dental care.

Option 4: Financing through our partnership with care credit - 6 or 12 months no interest.

The patient (or parent/guardian) is responsible for the payment of services rendered, and payment is due at the time of service. Fees, unexpected treatment, and financial questions will be discussed before treatment is performed. Fees are subject to change. Late fees and collection agencies may be utilized for any unpaid account balances 90 days past the date of service, and in default of payment, you will be required to pay these and any other fees associated with collection of account balance.

Please sign below, indicating agreement with this financial arrangement and authorizing the dental staff to provide dental services to the patient.

_____ _____

Patient Name Patient Signature DATE

_____ _____

Parent/Guardian Name Parent/Guardian Signature DATE