

Arizona Healthy Smiles
Shawn Young, DMD
1840 E. Baseline Rd. Ste. C-7 | Tempe AZ, 85283 1 48045654571 | www.healthysmilesaz.com

Written Financial Policy

Thank you for choosing Shawn Young, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment for services is due on the day services are performed unless other arrangements have been made and approved in advance.

PREFERRED METHOD OF PAYMENT:

On Day of Treatment: Cash, Check, Visa/MasterCard/American Express/Discover/Debit card/Care Credit**

**Subject to credit approval

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. We will gladly discuss your proposed treatment and answer any questions you may have. You must realize, however, that:

1. Your Insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. We encourage you to talk to your insurance company and familiarize yourself with your plan. We will do our best to estimate for you what your insurance will pay.
2. Not all services are a covered benefit in all contracts. Some plans arbitrarily select certain services they will not cover. Any amount not paid by your insurance, regardless of the reason, is your responsibility. We therefore require a credit card to be on file for any balance not paid by your insurance company.
3. BE AWARE that your insurance company will be mailing an explanation of benefits (EOB) to you. If your insurance company pays less than the estimated portion you can at that time contact them so they can answer any questions you may have. We will also be receiving a copy of your EOB. If there is a discrepancy between the amount the insurance company pays and the amount we estimate they would pay, we will send you a statement for the unpaid portion. When you receive the statement please remit payment by mail or contact our office to arrange payment. If we do not hear from you within 10 days of the statement date we will apply the balance to the credit card we have on file.

- Patients will be liable for all costs incurred if the account is forwarded to a collection agency.
- \$35 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Shawn Young, DMD charges \$35 for returned checks.

I, the undersigned, agree to all financial policies as listed above. If I carry insurance, I hereby authorize my insurance company to pay directly to my dentist.

Patient Name (Please Print) _____

Patient, Parent or Guardian Signature Date _____