Joseph G. DeFrancesco, D.M.D.
Oral & Maxillofacial Surgery
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BELLEVUE OFFICE
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www.drjdefrancesco.com

In an effort to provide you with flexible payment arrangements, the following is a list of our payment options.

Please indicate your manner of payment below:

_____ **Cash** ______ **Check** [Payment in full by cash or check at the time of treatment for services over $300 will receive a 10% discount]

_____ **Credit Card** [Visa, Master Card and Discover accepted]

_____ **Insurance** A claim will be submitted to your insurance. **The patient is Responsible for any remaining balance at the time of service** [I.e. co-pay, deductible, co-insurance and non-covered procedures]. Insurance amounts are never guaranteed, generally they are just estimates. If your insurance is denied **you are responsible for the full amount**. **The "remaining balance", after insurance, will be paid by :**
_______ Check _______ Credit Card ______ Cash

_____ **Dental Discount Plan** (Discount applied at specific plan's "flat rate for Specialists" when paid in full at the time of treatment)

_____ **Interest Free Financing with a *"Dental Fee Plan"*** Inquire at the front desk.

_____ **Care Credit ______ Health Savings or ______ Flexible Spending Account**

PLEASE NOTE: Any account that is not paid in full by the second billing [unless prior arrangements have been made] will be subject to an additional **finance charge.** With no payment after the third billing, the account will be sent to collections, **and additional collection fees added.**

If you have any questions or concerns about billing, the front office will assist you.

< ATTENTION!! We kindly ask for 24 hours notice for any cancellation..."NO SHOWS" will be charged $25 per half hour for not showing for any surgery appointments and failure to notify our office ahead of time!> (*Please initial* __________)

GUARANTEE OF PAYMENT:

I, ___________________________________, agree to these terms, acknowledge receiving
(PRINT NAME HERE)
a copy of this contract and accept responsibility to ensure full payment of all treatments rendered, plus collection costs, if I default on this agreement.

Signature: ____ Date: ______/______/______
[Patient, Parent or Guardian]

Witness (Office staff)**: _______________________________________**