BRYAN DENTAL GROUP ~ FINANCIAL POLICIES

442 West High Street, Suite 2, Bryan, Ohio 43506
419-636-3163 or toll free 866-729-2434
www.bryandentalgroup.com

Bryan Dental Group strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental that our patients deserve. We will provide you with an estimate of your total treatment costs and an estimate of your insurance coverage. Our goal is to help you afford your dental choices and maximize your dental benefits. This is an agreement between Bryan Dental, Inc. dba Bryan Dental Group, an Ohio Professional Corporation, as creditor, and the Patient/Guarantor/Debtor receiving this form. In this agreement the words "you," "your," and "yours" mean the Patient, Guarantor and/or Debtor. The word "account" means the account that has been established in your name(s) to which charges are made and payments credited. The words "we," "us," and "our" refer to Bryan Dental Group.

By executing this agreement, you are agreeing to pay for all services received.

Payment options if you have no dental insurance:
We request payment for services by cash, check, debit card, or credit card on the day treatment is rendered. A 5% courtesy is given if paid with cash or a check. With treatment involving laboratory fees (crowns, bridges, dentures, etc.) we request payment of 50% on the preparation date and the balance in approximately three weeks (or seat date). On extensive treatment, you may prefer to secure a bank, credit union, or third-party financing for the entire amount and make payments to the lending institution. We offer special financing through ***CareCredit*** with no-interest and low interest payment plans.

Payment options if you have dental insurance:
We request payment by cash, check, debit card, or credit card of your **estimated** deductible and out-of-pocket portion on the day treatment is rendered. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) we request your **estimated** deductible and co-payment on the preparation date. On extensive treatment, you may prefer to secure a bank, credit union, or third-party financing for your portion and make payments to the lending institution. We offer special financing through ***CareCredit*** with no-interest and low interest payment plans.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. Unless arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the due date on the statement. Your statement will show separately the previous balance, any new charges to the account, the finance charge, if applicable, and any payments or credits applied to your account during the previous 25-30 days. If your account balance after insurance is less than $1.00, we will write off the balance as a courtesy adjustment. Only credit balances more than $5.00 may be refunded.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 90 days of the time the service was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1 ½%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1 ½%) to the "90 Days Balance" of your account. The "90 Days Balance" is calculated by taking the balance owed 90 days ago, and then subtracting any payments or credits to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. At that time only emergency treatment may be rendered. All elective treatment will be taken off the schedule. If we refer your account to a collection agency, court or an attorney, you agree to pay all collection costs and court costs that incur. You also agree to receive electronic communications from them or us as a means of communication to collect this debt. If you choose to return once your balance is paid, you will be required to pay in full by cash, debit card, or credit card on the day services are rendered regardless of insurance.

Effective Date: Upon signing, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Guarantor name: _____

Signature: _____ Date: _____ 0622