



# FINANCIAL POLICY

Welcome to our practice. We are committed to making this an enjoyable and rewarding journey. A great smile is an investment for a lifetime and we want to make your experience as affordable as possible.

## METHODS OF PAYMENT

Monthly payment can be accomplished through a variety of options.

Method	When	Terms
Check/cash	Monthly	\$25 returned check charge to cover bank fees
Debit card	Direct debit 1 <sup>st</sup> or 15th	0% interest from us; no fees Paperless, automated
Credit Card Visa, Discover MasterCard	Auto charge 1 <sup>st</sup> or 15th	0% interest from us; no fees Interest per your credit card agreement Paperless, automated

Initial

**Monthly payment plan notes:** You will be provided a total fee that covers diagnosis, placement of braces, routine adjustments, retention and 2-years of retainer monitoring. Financing period of the patient portion is allocated over a number of months for your convenience and **may vary from the number of months in actual treatment** and is not tied to what is being accomplished in a particular month. Number of months of treatment varies on a number of factors including malocclusion severity, bone physiology and patient compliance and may be shorter or longer than the payment schedule depending on down payment, payment plan and treatment progress. Transfer out patients will be credited with any fees paid in advance of treatment progress. Accounts that are over 90 days past due may be outsourced for management to a collection agency which may affect your credit rating. An automatic payment plan is preferred. If this option is not chosen then payment is expected within 10 days of the agreed upon monthly charge date. Statements are only sent out for past due accounts.

Initial

**Insurance:** We accept most all dental insurance as an out-of-network provider. We participate in TriCare Dental, Delta Dental, MetLife, Cigna, Aetna and Humana plans. When you provide us with your insurance policy numbers we will be able to **estimate** the amount of your insurance benefit. The remainder not covered by insurance may be paid over a period of time with one of the above methods. The estimation of insurance benefits from your company is only that – an estimate based on current information. Changes in your insurance coverage will change ongoing benefits as insurance payments are periodic rather than paid in full at the beginning of treatment. Ultimately the billing party is responsible for payment of all fees for orthodontic care rendered by our office.

I have read and understand the financial policy of **Bentele Orthodontics, PC**.

\_\_\_\_\_ / \_\_\_\_/201\_\_\_\_  
Signature of Responsible Party    Date

## INSURANCE AUTHORIZATION – SIGNATURE ON FILE

I hereby authorize Bentele Orthodontics, PC to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize payment of healthcare benefits otherwise payable to me, directly to Bentele Orthodontics. I agree to be held responsible for all charges and services not paid by my insurance company. Valid only for orthodontic treatment by this practice.

\_\_\_\_\_ / \_\_\_\_/201\_\_\_\_    \_\_\_\_\_  
Signature of Responsible Party                          Date    Witnessed By



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