Nice Smile Family Dental
Allessandra M. Bennett Lowery, DDS, PLLC
3740 South Evans St, Suite C
Greenville, NC 27834

Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know** . . . The fee for the treatment rendered must be paid in full on the day of service.

- **Patients with insurance coverage need to know** . . . The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.

- **We accept Visa, MasterCard, Discover, Care Credit, checks, and cash for payment of the amount due. Payment plans are not available.**

- **One business day notice is required for rescheduling appointments**. A $35 fee will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 1 business day notice. Dr. Lowery does understand that unforeseen circumstances may prevent you from attending your scheduled appointment, however, you must not make missing appointments a habit. Dr. Lowery reserves your appointment time exclusively for you; she doesn't "double-book" and keep extra patients waiting in case you can't come. Please be considerate.

This is an agreement between Allessandra Lowery DDS, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by Allessandra Lowery, DDS and her staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

The Financial Policy continues on the back of this page.

Patient's Name: _____

Responsible Party (if patient is under 18 years old): _____

Signature: _____ Date: _____

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Allessandra Lowery, DDS.

Treatment Plans: You understand that if Dr. Allessandra Lowery has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by twenty-one (21) days after the statement date.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit- reporting agency such as a credit bureau.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1.0%) to the "overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Pitt County, North Carolina.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, or if we have to litigate in court. Or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Insurance Release: You authorize Dr. Allessandra Lowery to release any necessary information requested by your insurance carrier and authorize payment directly to Dr. Allessandra Lowery for any benefits available under your insurance plan.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

Transferring of Records: You may request by phone if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent