Payment Policy

In an effort to reduce cost, increase efficiency and maintain a high level of professional care, we expect payment of fees at the time services are rendered.

On reconstruction cases (crowns, bridges, partial, dentures, etc.) a 50% deposit is required before beginning treatment. The remaining balance may be made in 2-3 payments with final payment being due before the delivery of any case.

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. If you have a question about a treatment plan, fees or payment please discuss any concerns with our business manager before any treatment is started.

Method of payment can be one or a combination of the following: cash at time of visit, check at time of visit, Visa, MasterCard, Discover Card, or Pulse Card. A fee will be charged for returned checks.

Consent for Services

I HEREBY AUTHORIZE Dr. Callahan or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Callahan to make a thorough diagnosis of (name of patient)_____-'s dental needs.

Upon diagnosis, I authorize Dr. Callahan to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:_____
Signature of guarantor of payment/responsible party