Wall Family Dentistry
Dr. Charles Wall

OFFICE POLICY AND FINANCIAL AGREEMENT

I understand that all fees for me or my family are my responsibility. Dental insurance is a benefit, not intended to pay for all potentially necessary treatment, but a portion of the total cost. Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility. **All estimated fees are payable at the time of service.**

Preferred method of payment: (please select)

- **Cash or check 10%** discount at time of service only
- **Credit card** (discount of 7% for treatment over $500.00) at time of service. We accept Visa, Mastercard, American Express and Discover.

  Credit card #_____Exp._____CVC_____
- **Carecredit** This is a flexible payment option to make payments for 6-month interest free.

  Carecredit Acct. # _____
  Ask for details or application.
- Payment plans through Cherry Ask for details or application.

I agree to give Dr. Wall the authority to charge my credit card account for the entire balance if I have not paid. Amounts owing on accounts over 60 days will be charged 18% per annum. If account is not paid and is turned over to our collection/lawyer agency, there will be a **40% increase** for collection cost to your account

_____	_____	_____
Patient Name (please print)	Signature of Patient/Guardian	Date

_____	_____
Witness to Signature	Date