

Markus A. Watson D.D.S.

Distinctive General & Cosmetic Dentistry
332 Townsend Street
San Francisco, CA 94107

Our Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that helps you enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is a great investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. All of our fees or co-payments less than \$500 will be due and payable at the time treatment is rendered.

Initial _____

PAYMENT OPTIONS

Dental Fee Plan

No initial payment

Payment plans up to 60 months with low monthly payments which include a low fixed rate

Additional payment plans are available

Payments can be made at anytime without penalty

Fast, confidential service by phone, (888) 337-4171, or online at their secure website, www.dentalfeeplan.com good credit standing required

Payment in full (fees over \$500)

A bookkeeping courtesy of 5% is given for direct payment in full by cash or check at the start of treatment

A bookkeeping courtesy of 3% is given for direct payment in full by credit card at the start of treatment

Office payment plan

It is anticipated that treatment will take _____ visits. For your convenience, the treatment fee may be paid in ___ payments of \$_____ billed directly to your account monthly

Initial _____

Card Number _____ Exp Date _____

Account Number _____ routing Number _____

Dental insurance

We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated payment or coverage because the insurance policy is an agreement between you and your insurance company, we ask that all patients be responsible directly for your charges. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Initial _____

There will be a fee for any additional procedure(s) NOT included in original treatment plan. If for any reason the insurance company does not pay the estimated amount, it becomes your obligation

We accept Visa, MasterCard, Discover and American Express

Patient or Responsible Party's Signature: _____

Date _____

Financial Officer: _____ Date _____