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FINANCIAL POLICY

Thank you for selecting our office for your endodontic treatment. Our objective is to provide you with outstanding dental care. For this reason, we want to provide you with a thorough understanding of our financial policy.

The fee for endodontic treatment is based upon the complexity of your treatment plan and the internal structure of the tooth. We will review the fees associated with your treatment plan after our doctor has performed a thorough evaluation of your case. Payment is due for all services rendered on the date of service.

You shall be directly responsible for all payments for treatment, regardless of insurance coverage. The office shall make all reasonable attempts to assist with insurance coverage but the ultimate responsibility for payment remains with the patient or legal guardian.

For use of a credit card, a 2.3% merchant fee will be added to your balance. This does not apply to debit, HSA, and FSA cards.

The following cases will require a deposit of the estimated out of pocket expense prior to your appointment.

- *Oral Sedation
- *Multiple Teeth/Large Cases

I hereby provide consent and approval for the office to charge me for reimbursement of any credit card fees and expenses incurred by the office and/or its business support provider in allowing payment by credit card.

Patient Name: _____

Patient or Parent/ Guardian Signature: _____

Date: _____