

Office Financial Policy

Super Smiles Dentistry
500 N. Main St, Suite A
Harrison, AR 72601

08/27/2019

It is the policy of this office to make complete payment arrangements at the time of the office visit. This may be handled in one of the following ways:

1. If you have dental insurance, we will submit the insurance for you. The remaining balance is your responsibility. At the time of the appointment we expect you to pay your portion on the day of service.
2. If you do not have dental insurance, payment is expected at the time the services are rendered. If you would like to arrange for a monthly payment plan, please speak with our office manager.

By signing below as a legal guardian for the minor receiving the care, I agree to accept full responsibility to pay for all charges Super Smiles Dentistry considers appropriate and necessary. I understand that I am in default of this agreement if charges for care are not paid within 60 days after date of treatment. As a result of this default, this office reserves the right to add a 12% interest annually of 1% interest monthly on the outstanding balance. In the event that my account is submitted for collection, I understand and agree to be held responsible for all reasonable costs of collection, including court costs and reasonable attorney's fees.

There is a \$25.00 charge for any returned checks.

Parent/Guardian Signature: