Florissant Dental Services
504 N New Florissant Road | Florissant MO, 63031 | 3148318500

Written Financial Policy

Thank you for choosing Florissant Dental Services. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Florissant Dental Services

*Florissant Dental Services requires payment at the time of service. Fees for treatment are the responsibility of the guarantor. For the convenience of our patients we accept cash, check, Mastercard, Visa, Discover, American Express.
______ date________

*For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. ALL CO-PAY AMOUNTS ARE ESTIMATES. WE DO OUR BEST TO PROVIDE ACCURATE ESTIMATES BUT THE FINAL PAYMENT IS BASED SOLELY ON YOUR INSURANCE COMPANY[3] Any amount that the insurance company does not pay based on our best estimates is the responsibility of the patient.
________ date________

*Patients may choose to use CareCredit or Chase Health Advance[2], which offer some programs w/ 0% interest options[1]. While Florissant Dental Services absorbs a portion of the processing fee, we are required to include a small portion of this processing fee to the patients account. Since the practice is already absorbing costs for the convenience of these creditors, additional discounts will not apply. ________ date ________

*A fee (currently $27) is charged for patients who miss or cancel without proper notice. We ask that our patients call us immediately if they need to change or cancel an appointment.
_________date _________

*Florissant Dental Services charges $25 for returned checks __________ date ________

*Florissant Dental Services allows small discounts for patients that qualify. These include a 5% discount for patients over 64 years of age and a 5% courtesy adjustment to patients who pay for their treatment with cash, check, at least 24 hours prior to the beginning of care for treatment plans of $1,000.00 or more. However, only one discount may be applied.
________date __________

*Please do not hesitate to ask any questions you may have. We are here to help our patients.

Patient, Parent or Guardian Signature Date Patient's Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 7 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.