Bowser Center for Advanced Dentistry Payment Agreement

Thank you for choosing Bowser Center for Advanced Dentistry. We appreciate the opportunity to care for you and your family's dental needs. The following information is provided to answer questions and avoid confusion regarding payment for dental services.

For patients with dental benefits: As a courtesy, our office will file your claim with your insurance company and work with the company to provide the necessary information to maximize your benefits. Any amount not received from your insurance company is your responsibility.

For patients without dental benefits: If you do not have dental insurance, you will be responsible for the full cost of your treatment. Payment for services is due at the time of treatment unless you have a signed financial arrangement.

We accept cash, personal checks, and the following credit cards: Visa, MasterCard, and Discover. We also offer No-interest financing plans.

We are pleased to offer a 5% savings to patients with a treatment plan over $500. The treatment must be paid in full on the day of service by cash or check.

Appointments missed or cancelled less than 48 hours in advance may be charged a $30 fee.

If payment has not been made in full after two statements, a rebilling fee of $25 will be added to each additional statement. This fee will be reversed any month a personal payment is received. The reversal will occur when the personal payment is posted to the account and will be reflected on your next statement.

I understand and agree to the above payment agreement.
Signature: _____
Date: _____

Bowser Center for Advanced Dentistry Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication necessary. I understand that using anesthetic agents embodies certain risks. I understand that I that I can ask for a complete recital of any possible complications.

Signature: _____
Date: _____