1636 Nicholasville Road STE 2
Lexington KY 40503
859-277-1124

Financial Policy

Our office is committed to providing you with the best dental care possible. In order to achieve this goal, we need your assistance and understanding of our financial policy. In order to serve you better we have prepared several payments options; ***please initial*** which suits you best.

_____ **Self Pay** - You are responsible for your fees at time of service. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. Your balance must be paid in full.

_____ **Dental Insurance** - Most dental plans do not cover all endodontic services in full. Your estimated out of pocket will be due on the day services are rendered. **If you have any questions regarding your insurance or estimated co-pay, please ask prior to treatment.**

_____ **Care Credit**- This is a credit card. You must apply before your appointment, PRIOR TO TREATMENT. You are responsible for your fees at time of service and your financial agreement is with Care Credit. We offer 6 months interest free. Please ask for further details.

I understand fully that I am responsible for my account at Bluegrass Endodontics and agree to pay according to the selection above.

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for services, unless I notify the office to the contrary in writing. In this section, calls and text messages include but not restricted to pre-recorded message, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contacted, unless I notify the office to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the office.

_____ _____

Patient (Guardian) Signature Date

Payment is due upon services rendered.