

# Mulberry Street Family Dentistry

950 North Mulberry St Ste 170 | ELIZABETHTOWN KY, 42701 | (270) 360-1084

## Our Office and Financial Policy

Thank you for choosing Mulberry Street Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. Following your diagnosis, the doctor will advise you of the plan for treatment. 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. Payments for today's visit and future visits are due at the time of treatment. We expect your co-pay on the same day as your visit and will gladly work with your carrier to maximize your benefit and file initial dental insurance claims for you. You will be responsible for making sure we have the correct information. Claims that need to be resubmitted will be charged a \$10.00 administrative fee.

### Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from CareCredit
  - Allow you to pay over time with NO INTEREST<sup>1</sup>
  - Convenient, low monthly payment plans<sup>2</sup> also available
  - No annual fees or pre-payment penalties
  - <sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
  - <sup>2</sup>Subject to credit approval

Please note:

A fee of \$25.00 is charged for patients who miss or cancel without 24-hour notice. However, if you know you must cancel/change your appointment please call us as soon as you know.

Mulberry Street Family Dentistry charges \$25 for returned checks, plus any bank fees.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

<sup>3</sup>If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Patient, or Guardian Signature

Date

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)