Payment Options
for
Mark Corn D.D.S., P.C.

Dr. Mark Corn strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an ***estimate*** and is valid for 30 days. Some or all of your treatment may not be covered due to plan limitations that have not been disclosed to us. It is your responsibility to contact your insurance company to determine which services are covered under your plan. If your dental plan does not pay the amount we have estimated, the balance is your responsibility. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate you choice of payment.

Plan A: For patients with dental insurance, the uninsured portion is due at the time of treatment. We will be happy to bill your insurance for you. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any out-standing balance and seek reimbursement from your dental plan.

Plan B: All payments made to this office can be made with the following options: cash, check, debit card, or credit card. I prefer to use _____for future payments.

Plan C: For those who need extended payment arrangements, we are pleased to offer an extended monthly payment plan option through a dental financing company called Care Credit (www.carecredit.com). Please see our receptionist prior to treatment for more details and to receive a loan application.

Please note: To demonstrate our appreciation for patients who are prompt with full payment, we will extend a five percent (5%) reduction. This applies only to treatment plans of $500 or more. We are unable to offer the 5% discount to Care Credit accounts and PPO accounts.

I accept full financial responsibility for my account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

In order to ensure that my account is kept current, I will allow this office to keep my credit card account number on file. This account will only be used if my account becomes delinquent after 60 days for any reason.

Credit Card No._____ Exp. Date_____

Visa MC AmEx Discover

Printed Name:_____ Date:_____

Signature:_____