Arizona Sunset Dental, P.C.
2205 W Magee RD #124
Tucson, AZ 85742
(520)797-4551

WRITTEN FINANCIAL POLICY

Thank you for choosing Arizona Sunset Dental. 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 the following payment options.

You can choose from:

-CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS OR DISCOVER.
There is a service charge of $35.00 for returned checks.

-We offer a 3.5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $500.00 or more.

-NO INTEREST* PAYMENT PLANS* FROM CARE CREDIT*
- Allow you to pay over time with no interest*
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Please Note:
Arizona Sunset Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring more than 1 appointment, a two portion payment arrangements may be provided. For larger, more comprehensive treatment plans, a deposit of $50.00 is required to secure your initial appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement of your treatment. We do this as a courtesy to you and need you to be aware that the contract is between you and your insurance company. Any amount denied by your insurance company is the sole responsibility of the patient. **Patient Initials: _____**

***A $50.00 fee is charged for patients who miss or cancel appointments without a 48 hour advanced notice.** **Patient Initials: _____**

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. **Patient Initials: _____**

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

_____
Patient, Parent or Guardian Date

_____
Patient Name (Please Print)

*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required
*Subject to credit approval
*However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
*No discounts will apply if using this method of payment.