SIMPSON DENTAL ASSOCIATES
400 ALLEN DIVE
CHARLESTON, WV 25302
PHONE: 304-342-6162

To Our Patients:

Our goal is to provide the highest quality dental care using only the finest materials and most advanced techniques. We constantly strive to keep abreast of new technology by continuing our education, and we maintain a highly skilled staff. Our fees are consistent with the quality of care we provide. In order to keep our fees as low as possible we expect payment at time of service. If this is not possible, please discuss this with the doctor prior to treatment.

The following is a list of payment methods available to you:

- Cash
- Personal Check or Money Order
- Visa, MasterCard, American Express, or Discover
- Financing through Care Credit or Lending Club

All accounts will be assessed a 1.75% (21% APR) monthly charge on balances 30 days past due. If you need the benefit of financial arrangements, please complete a Care Credit or Lending Club application which is available upon request.

As a convenience to our patients, we will continue to help with your insurance. Please be advised that insurance companies vary widely in their services, policies, and amounts they pay for treatment. If you have insurance, we are pleased your dental benefit program will assist you in obtaining and maintaining a superlative level of oral health. Our office staff "understands" dental insurance, and will be glad to assist you in obtaining the maximum benefits specified in your contract.

You must realize, however, that:

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally, but not necessarily, covered by the maximum allowance determined by your carrier.
3. Not all dental services are covered benefits in all contracts.
4. You are responsible to us for all fees for services rendered to you.

Your insurance carrier's goal is to provide the lowest quality care available. Our goal is to provide you the finest care available. We will gladly discuss your proposed dental treatment and answer any questions you might have regarding the involvement of your insurance benefit program.

_____ _____
Patient / Guardian Signature Doctor Signature

_____ _____
Witness Signature Date