



923 6th Avenue
DeWitt, Iowa 52742

Written Financial Policy

Thank you for choosing DeWitt Family Dentistry. 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 several payment options.

Payment Options:

You can choose from:

-Cash, Check, or Credit or debit Card

We offer a 5% courtesy discount to patients without insurance who pay for their treatment at the time of service or prior to completion of care.

-Convenient monthly payment options from CareCredit Healthcare Credit Card

Allows you to pay over time 6 months with no interest

No annual fees or pre-payment penalties

Please note:

DeWitt Family Dentistry requires payment at the completion of your treatment.

For patients with dental insurance we are happy to directly bill them for reimbursement for your treatment.

A fee of \$25 is charged for patients who miss or cancel without 24-hour notice.

DeWitt Family Dentistry charges \$25 for returned checks.

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

All past due accounts are subject to a finance charge of 1.5% per month or maximum rate allowed by law. The undersigned responsible party promises to pay for services in accordance with the above terms. If, at any time, for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes DeWitt Family Dentistry PC to bill their account finance charges and collection fees will be added to your account as described above. In the event it becomes necessary for DeWitt Family Dentistry PC to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned promises to be responsible for charges incurred, to pay all additional costs, charges, collection fees and expenses, including reasonable attorneys' fees and costs, if incurred for the collection or otherwise and submits to jurisdiction and venue in Clinton County Iowa.

Patient, Parent or Guardian Signature _____ Date _____