Optimal Dental
Plaza Mall South
1919 S. 40th Street, Suite 218
Lincoln, NE 68506

Thank you for choosing our team of dental professionals to serve your dental needs. Our team is committed to providing you with the highest quality of care, in the safest environment. We appreciate the confidence you have placed in us and will do everything possible to warrant your confidence as we serve your dental needs.

Your treatment costs will be fully disclosed to you prior to scheduling any treatment to provide you an opportunity to openly discuss your treatment and payment options. Our fees reflect our commitment to the quality of care that our patients deserve.

If you have insurance, we will be happy to assist you in processing your insurance claims to maximize your benefits. Insurance is designed to **offset** the cost of your dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses. Please note that insurance estimates and pre-authorizations are **not a guarantee** from your insurance company. We ask you to keep in mind that your insurance policy is a contract between you and your insurance company - and that we are not a party to that agreement. Regardless of insurance coverage, financial arrangements between the patient and our office will ultimately be the patients' responsibility.

To indicate how you will honor your commitment to our practice, please select from our list of available payment options:

_____**Payment in full day of service** by personal check, cash, Visa, MasterCard, Discover or American Express.

_____**Payment Plans** available with approved credit. These are interest-free to the patient. Ask us for an application or go to the link on our website.

_____**Insurance coverage**; estimated co-insurance is due and payable at the appointment by any of the above payment methods. Please present insurance card at check-in. Insurance payments will be posted to your account on the day we receive them and a statement of account showing any remaining balance due will be mailed to you.

I understand that any late payment will be subject to a 1.33% per month (16% per annum) finance charge, and that insurance estimates are estimates only. I also understand that I am responsible for any claims not paid.

Patient:_____ Date:_____

Financial Coordinator:_____ Date:_____