Heim & Carroll DMD LLC

36 Welles Street Suite 240
Glastonbury CT 06033

Payment Policy

Thank you for choosing Heim & Carroll DMD LLC as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you or your family member receive treatment. Please indicate your preferred method of treatment.

My preferred payment option is:

_____ Cash

_____ Check

_____ Major Credit Card (Visa, Mastercard, Discover)

A note to patients with Insurance:

Dental insurance usually does not cover the total cost of treatment. Based on your plan, we usually can estimate the amount of your co-payment. Your co-payment is expected at the time of service. If your insurance company fails to pay within 60 days after we submit the claim, you will be responsible for the full fee.

Acceptance Agreement:

I understand and accept the above financial policy. I understand the parent or relative bringing a dependent for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for all fees, regardless of insurance coverage.

Patient/Responsible Person:

Print Name _____

Signature: _____

Date: _____