Robert Eversole DDS, PC

1315 W Westridge Pkwy | GREENSBURG IN, 47240 | (812) 663-8088

Written Financial Policy

Thank you for choosing Robert Eversole DDS, PC. 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.

Insurance Coverage:

Primary Dental Insurance Co: _____ Name of Insured: _____
Insured's Birth date: _____ Insured's Social Security No: _____
Insured's Employer's Name: _____ Phone No: _____
Patient's Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other
Insured's Address: _____ Phone No: _____

*For patients with dental insurance we are happy to file your claim with your insurance carrier. An estimated payment of your costs and deductible is due at the time services are rendered.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Smiledash.com for online bill pay
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Robert Eversole DDS, PC requires payment **prior** to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

A fee of $40.00 is charged for patients who miss or cancel their appointment without 24-hour notice.

Any balance not paid within 30 days will be subject to an 18% finance charge. Robert Eversole DDS, PC charges $35 for returned checks.

For treatment plans requiring multiple appointments, we will accept payment in thirds when the cost exceeds $2,000.00 and arrangements have been made in advance.

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

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval