Crestview Dental Associates
41 East Avenue
Westerly, RI 02891
401-596-0319
crestviewdentalassociates.com

FINANCIAL POLICY INFORMATION

Thank you for choosing Crestview Dental Associates. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Payment is collected in full at time of service unless prior arrangements have been made with the Office Manager.

Our office accepts cash, check, Visa, MasterCard, American Express, and Discover.

Our office accepts Care Credit, a special healthcare financing option. Please ask a team member for details.

Please note:

If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans, a deposit is required.

For patients with dental benefits, we are happy to work with your carrier to maximize your benefit.

Crestview Dental Associates reserves the right to charge a fee for returned checks or insufficient funds.

Crestview Dental Associates reserves the right to charge a fee for appointments cancelled or rescheduled with less than twenty-four hour notification.

Any account balance over 60 days will incur a 1.5% finance charge per month. Additional charges may incur if the account is placed for collection.

Authorization:

I assign directly to Crestview Dental Associates all dental insurance benefits, if any, for myself and/or my dependent(s). I understand that I am responsible for all fees incurred for my dental treatment and agree to pay accordingly. I am aware that I am responsible for all charges whether they are paid by dental insurance or not. I authorize the use of my signature for all insurance company submissions. Crestview Dental Associates may use my dental/medical information and may disclose such information as needed for the purpose of obtaining payment for services and determining insurance benefits.

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Signature of patient (parent or guardian if under 18)   Date