Rosalynd Alatorre DMD

2815 S RAINBOW BLVD | LAS VEGAS NV, 89146 | (702) 362-9974

**Written Financial Policy**

Thank you for choosing Rosalynd Alatorre DMD. 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, Visa®, MasterCard®, American Express® or Discover Card®

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment (cleanings are NOT included) with Cash prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Options¹ from CareCredit Healthcare Credit Card

* Allow you to pay over time
* No annual fees or pre-payment penalties

Please note:

Rosalynd Alatorre DMD requires payment at the time services are rendered. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment as a courtesy to you. Your estimated copayment is due at time services are rendered.

A fee of $75.00 is charged for patients who miss or cancel without 48-hour notice for any dental hygiene appointments. Dr. Alatorre will charge $150.00 for every hour that was scheduled.

Rosalynd Alatorre, DMD charges $30 for returned checks.

A $25.00 charge will be assessed to all collection accounts, in addition to accrued interest. If your account is referred to our Collection Agency, interest will continue to accrue. In addition, you will be responsible for all added percentage-based Collection fees / costs per our prevailing collection company contract, Attorney fees, Court Costs, Service Fees and associated Miscellaneous Fees and Costs.

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

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

¹Subject to credit approval