FINANCIAL AGREEMENT

Payment is due at time of service unless prior arrangements have been made.

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our front desk for an approximate cost prior to treatment. For convenience, we accept cash, check, VISA, MasterCard, Discover, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE

If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. We charge a $10 billing charge for any statement sent 90 days after charges were incurred.

In consideration for the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency and a collection fee of 40% of the account balance will be added and must be paid by the patient. I grant my permission to you to telephone me at home to discuss matters related to this form. After 2 consecutive missed appointments, it is our policy not to reschedule you for any further appointments. There is a $25 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or charge on ly.

We require a 24-hour notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $40 charge for a missed appointment if notice is not given.

I have read and understand the above financial and office policy agreement.

_____ _____

Patient name *Date*

_____ _____

Patient/Legal Guardian Signature *Date*