Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. If payment is not received from your insurance company within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you, we help process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. **Nevertheless, any payments made directly to you by your insurance company must immediately be remitted to us by you.** In order for our practice to file your insurance claim, you must bring proof of insurance at each appointment.

Your **estimated** co-payment for treatment, which is the amount not assisted by your insurance, is due at the time treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and American Express, Third party: extended payment financing is available upon request and approval.

Returned checks will be assessed a $25 service fee and balances older than 60 days will be subject to collections fees and finance charges at the rate of 1.5% per month (18% annually). **In addition, a $30.00 fee will be charged each month until balance is paid in full.**

Our practice requires 48 hour notice if you cannot keep your scheduled appointment. If you miss three appointments without giving us the required 48 hour notice, you will be requested to find a new provider for your dental needs. If you are 10 minutes late or more for an appointment you may be asked to reschedule or treatment may be altered.

TURN OFF CELL PHONES. Please make arrangements for your children if you are having a procedure done at that visit.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Signature of Patient or Responsible Party Print Name of Patient or Responsible Party

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Date