



DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

GENERAL:

Understand that regardless of any insurance status, you are responsible for the balance on your account. You are responsible for any and all professional services rendered, including but not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation at least 24 hours in advance, you will be charged \$55.00. Please help us better serve you by keeping scheduled appointments.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits you have.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. The balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

Unpaid balance over 60-90 days old will be subject to monthly interest of 1.5% (APR 18% or collection fee of 35% of total unpaid amount). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____ Date: _____