FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material 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 excellent service to you while minimizing our administrative costs.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard and Visa. Outside financing is available through CareCredit® upon request and approval.

All charges you incur are your responsibility regardless of 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 a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement.

Returned checks and balances older than 60 days may be subject to collection fees. Our returned check fee is $20.00.

For **non-insured patients**, payment in full is required at the time of service.

For **all patients**, accounts that are not paid in a timely manner will be turned over to a collection agency. The patient or person responsible for the account agrees to pay any finance charges, attorney fees, court costs or any other cost of collection.

A 24 hour notice is required for any cancellation or reschedule. Otherwise, you will be charged a $35.00 “No Show Fee”.

If you have any questions regarding this financial agreement, please ask. We are committed to providing you with the most positive experience in dental care.

I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES ASSOCIATED WITH MY TREATMENT AS WELL AS UNPAID BALANCES BY MY INSURANCE COMPANY. UPON MY TERMINATION OF CARE, I WILL PAY MY BALANCE DUE IN FULL.

Print Name _____

Signature _____ Date_____