FINANCIAL AGREEMENT

Payment for the patient's portion of dental services is due at the same time dental services are rendered. Our office will be happy to process your insurance claim. Insurance estimates are provided as a courtesy, however they are estimates. In the event that your insurance carrier pays less than the estimated amount, the patient is responsible for the full unpaid balance. Pre-determinations are performed upon request, however are not a guarantee of benefits. We accept cash, checks and for your convenience MasterCard, Visa and Care Credit.

Our staff will do their best in going over your treatment and answer any questions relating to your insurance. Please understand however, that:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover and may have limitations. **It is the patient's responsibility to review and know their policy and its limitations, as it is an agreement between you and your insurance company.**
3. Our fees are considered usual, customary and reasonable and fall within the acceptable range for most dental insurance companies in our demographic area.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

- **Broken Appointment:** There will be a $25.00 charge per ½ hour for time reserved for the 2nd failed broken appointment, unless 24 hours notice is given. Multiple missed appointments may result in dismissal of services.
- **Checks Returned and NSF:** There is a $30 charge for check returns and NSF per incident.
- **Finance Charge:** Over 30 day balances are subject to a 1% interest rate per month, 12% per year charge on your account.
- **Duplication Fee:** There is a $24 charge for duplication of records per person. It may take 7-10 days for records to be processed.
- **Long Distance Patients:** Please note that services are ***AT YOUR OWN RISK***. We do not offer refunds in the event that you are unable to travel to our office for any follow up treatment.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for all dental services rendered. I have read all the information on this financial agreement and have completed and updated my health history form as needed. I certify that the information is true and correct to the best of my knowledge.

I authorized and give consent for dental treatment of the person named above and agree to pay all fees and charges for such treatment and services rendered. I agree that as the Parent and or/ legal guardian of the minor receiving dental care at this office, I am ultimately responsible for all payment of fees for dental services rendered to the minor in my care.

I authorized this office to release information relating to my dental care to my insurance company. I desire that all dental insurance check payments to be sent directly to the dentist.

Patient Signature (Parent or Legal Guardian) Date

Witness / Reviewed By Date