

FINANCIAL AGREEMENT

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. Before treatment, you will be advised of the approximate cost. For convenience, we accept cash, check, Visa, MasterCard, American Express & Discover. All emergency dental service performed without previous financial arrangements with the office manager must be paid for AT THE TIME OF SERVICE.

Scheduled Appointment Policy:

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that our patients make every effort to keep their reserved dental appointments. As a courtesy, our office will call in advance to confirm all patient appointments. Broken and missed appointments create scheduling problems for other patients as well as our practice. **If you find that you must change your appointment, we require a minimum of 24-hour notice so that we may accommodate another patient. Each missed or cancelled appointment, if less than 24-hour notice is given, will result in a \$50.00 charge for each hour of scheduled appointment time.**

Patients Not Covered by Dental Insurance

Payment in full is expected when services are rendered.

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 and you are responsible for your entire bill regardless what your insurance pays. We are only a third party providing the service to you. This office requires that you will be responsible for your co-payment and deductible at the time of service. After insurance has been filed and benefits have not been received within 60 days from your insurance company, the entire balance becomes patient responsibility. A refund will be given when the benefits have been received from the insurance company. This office cannot render services on the assumption your charges will be paid by your insurance company.

In consideration for the professional service rendered to me by the doctor, I agree to pay for those services in full. In the even that my account becomes delinquent, I understand that my account will be turned over to a collections service. Additionally, I agree to pay any court costs, attorney fees, and collection fees which may be associated with my account. I grant my permission for you to telephone me at home or work to discuss matters related to this form.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICY AGREEMENT.

Patient/Guardian Signature _____ Date _____