Dental Services Financial Agreement

Our goal is to help you establish excellent oral health. Our team is committed to helping you determine the more appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence, or fees for services, please ask for clarification before treatment is begun.

Our financial policy is as follows:

- We accept cash, checks, debit cards, and credit cards.
- Payment is due at the time of service. Patients receiving major restorative treatment are required to pay a minimum of 50% at the time of preparation and those patients without insurance are required to pay the remaining balance prior to final cementation.
- Payment plans for certain procedures are available through care credit with payment options available up to 24 months at fixed rates.
- Insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. We will be happy to assist you by filing your insurance claim and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. **The responsibility for payment belongs to the patient.**
- We will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of benefits may be advisable if there is a question concerning coverage .
- Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment is begun.

We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, a minimum 20% copayment is due at the time of service.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all dental charges for dental services and material not paid by my dental plan, unless prohibited by law if the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all dental claims.

I hereby authorize and direct payments of the dental benefits otherwise payable to me, directly to the dentist or the dental entity.

Should your insurance plan be denied, full payment is expected at the time of service unless prior arrangements have been made through our office manager.

Please remember that you are responsible for timely payment of your account. “In the event of nonpayment I agree to be responsible for any legal or collection fees. The collection fee is a percentage of the total balance turned over to an outside agency. I agree to be responsible for these fees.”

Broken appointments are a loss to everyone. Please inform us 24 hours in advance of any appointment changes to avoid a $25.00 fee.

I understand the above policy and agree to the terms herein.

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Signature Date