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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.

For all other plans, we are considered **"out of network".** As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office. By signing this form you assign benefits to our office. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment. 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. Any insurance reimbursement monies will be applied to your account or refunded back to you.

All charges you incur are your responsibility regardless of your 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.

Our office accepts cash, personal checks, American Express, Discover, MasterCard and Visa. Outside financing is available through CareCredit upon request and approval.
Returned checks will be subject to a fee of $30.00 and finance charges on balances over 30 days accrue at the rate of 1.5% per month (18% annually).

Additionally, our office will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hour notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I have read the above information and I fully understand I am responsible for the fees charged and payment of my account.

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Patient Signature Date