Financial Agreement Form

Thank you for choosing our practice to provide your dental care needs.

We are committed to providing high quality care for our patients. Our goal is to help you reach the best oral and optical healthcare possible.

Insurance:

Your insurance coverage is a contract between you, your employer, and your insurance company. As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up to date insurance information. With this we will **estimate** the insurance portion and your co-pay. This may or may not be what the insurance will actually pay. We will do our best to help you receive maximum benefits. We will wait 60 days for claims to be paid, after 60 days if payment hasn't been made, you will be responsible for payment and seeking reimbursement from your insurance company.

Initial ________

Payment Options:

Payment is expected at the time of your service. If you have insurance, we will provide an estimate of your co-pay and collect your portion at the time of your appointment. We accept cash, checks, Visa, MasterCard, and Discover. We also offer Care Credit, a healthcare financing program that offers interest free payment options upon approval.

A late fee of 3% will be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Returned check fee is $35.

Initial ________

Minor Patients:

Please plan to be present at appointments with your children under 18. If you cannot be here, please make prior arrangements with our staff. The parent or guardian accompanying the minor is responsible for payment. In case of divorce, regardless of decree, the parent who brings the child is responsible for payment. We are unable to bill separate parties; therefore the parents are expected to work out the details.

Appointment Changes:

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask to give us a minimum of 24 hours notice. If 2 or more appointments are broken in a 12 month period without notice, all future appointments will be cancelled and patients will be placed on a priority list for their next visit.

Patient Name: ____________________________ Date: ______________

Patient Signature: _____________________________

Provider Signature: __________________________