FINANCIAL AGREEMENT

We have established guidelines for payment of financial obligations for services rendered in our office so that there is no miscommunication. We will be happy to answer any concerns you may have. **We accept Checks, all major Credit Cards and Insurance (patient portion is due at time of service). We also accept Care Credit as an outside financing source.**

We require that you pay 25% of services at the time your appointment is scheduled to hold your reserved surgery appointment. If you have dental insurance, any adjustments will be made when payment is received from your insurance carrier.

Responsible Party Contract

I understand that any expected payment from my insurance company is an **ESTIMATE** only and I am responsible for all fees in their entirety. I also understand my benefits are based upon a contract between my employer and the insurance company and not this dental office. I am responsible for the total fee if the insurance company doesn't pay for a particular service and/or responsible for the difference if the insurance company only partially pays for the service. If a medical denial is needed for your dental plan to pay, the patient will be responsible for obtaining the denial (otherwise you are responsible for the balance). ***I understand if prior written financial arrangements have not been made, then the fee is due, in full, day of service.*** No balance shall be carried by this dental office for more than 60 days. If my account is sent to a collection agency or to an attorney for non-payment, I will be responsible for reasonable attorney fees, collection expenses and accruing interest in addition to my unpaid balance.

NOTE: We **do not** file ***Medical claims or Medicare***.

A $60.00 FEE WILL BE ASSESSED FOR FAILED APPOINTMENTS – WITHOUT 48 HOUR NOTICE

I have decided on a payment option and understand my financial obligation with this office.

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Signature **Date**