FINANCIAL AGREEMENT

Patient Name: Birth Date: Date Created:

We want our patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following financial options:

1. Patients with Insurance: Estimated portion not covered by insurance due at time of service.

2. VISA – Mastercard – American Express and most of major credit cards

3. Patients without Insurance: Payment for dental services is due at the time of treatment.

For Our Patients with Dental Insurance

Because we understand that dental insurance plays a role in helping many people defray some of the costs of dental care, we would like to share with you the following facts about dental insurance:

• Dental insurance is not meant to be a pay-all. It is meant only to assist in paying for your dental care.

• Dental insurance plans do not necessarily correspond to individual patient needs. As such, many routine and necessary dental services are not covered, even though you may need those services.

• Our responsibility is to provide the best treatment for our patient's needs, not to compromise care by trying to match the coverage of different insurance plans.

• In spite of what your plan says, we've found that many plans actually pay less than what you might expect.

• The benefits your plan pays are largely determined by how much your employer/union pays in premiums forthe plan.

PLEASE NOTE that we are happy to submit your claims and help you to receive the maximum benefits due to you, but please understand that we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims.

Appointment Policy:

Your appointment time is reserved specifically for you. We ask for at least a 48 hours notice if you need to reschedule your appointment.This will allow us an opportunity to schedule another patient in your place. It is our policy to charge a $100 per hour fee for missed appointments and for individuals who do not give us a 48 hour notice.

Signature:

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I, not my insurance company, am ultimately **FINANCIALLY RESPONSIBLE** for payment in full **AT THE TIME OF SERVICE FOR ALL SERVICES RENDERED**. I also understand the above cancellation policy and charges.

Signature of Patient, Parent or guardian: _____