DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing our office for your dental care. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: Dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by our dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.00 per hour you were scheduled. Please help us service you better by keeping your scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including insurance verification, and pre-treatment estimates submitted upon your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchaser for you.** If you have any questions concerning any estimates and/or fees, it is your responsibility to have these answered prior to treatment to minimize any confusion.

**Please be aware some services provided may not be covered by your insurance. Any balance is your responsibility whether or not your insurance pays any portion.

PAYMENT: Full payment is due at the time of service. If insurance benefits apply, the estimated patient portion and deductible is due day of service, unless prior arrangements have been made. **We accept cash, check and credit/debit cards.**

Unpaid balance over 30 days may be subject to late fees. If payment is delinquent, the patient will be responsible for payment of collection, attorney's and court fees associated with the recovery of the monies due on the account.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature_____ Date:_____