

**Financial and Appointment Agreement**

Our goal is to provide the highest quality of dental care with a clear communication of our financial policy.

**DENTAL INSURANCE:** Our office will gladly work with you to help get the maximum benefit available to you. Many dental insurance plans do not cover 100% of your treatment costs. Therefore, you will be expected to pay your **deductible** and your **estimated co-payment**. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions): therefore, **we cannot guarantee any estimated charges**. Please know that we will do everything possible to help you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 30 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. ***We will gladly file all dental claims for any given treatment, but we are not party to any insurance programs or contracts*** ***Your policy and benefits are an agreement between you and the insurance company so ultimately you are responsible for all charges.*** ***It is your responsibility to inform us of any changes in your insurance coverage.***

**REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER:** All ESTIMATED portions and deductibles are due prior to treatment. In the event your insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

**TREATMENT PLAN ESTIMATES:** We prepare TREATMENT PLAN ESTIMATES so that patients can understand their estimated cost of recommended restorative treatment prior to start. This Estimate is a good-faith attempt to predict the cost of your treatment based on the known facts when estimate is made. As your treatment progresses, your dentist may determine in consultation with you that additional or a change in treatment may be necessary and that would change the estimated cost.

**NSF CHECK POLICY AND COLLECTIONS:** Payments made by check that are not honored by the bank will incur a returned check fee of $50.00. The payment will be reversed from the appropriate account when a check is returned by the bank which could result in additional fees being assed to the account. Returned check reimbursement payments must be in the form of cash, cashier’s check, certified funds or money order.

**MISSED/ BROKEN APPOINTMENTS:** We respectfully ask that you give us a minimum of 48 hours’ notice to cancel or reschedule your reserved appointment. A broken appointment is defined as one for which the patient failed to show-up or cancelled an appointment with less than 48 hours’ notice. If two (2) appointments are missed or rescheduled without the required notice, we may be unable to reserve time for you on our schedule. All adult patients are required to sign for minors/dependents and themselves. Broken appointments may be subject to a $25.00 fee.

**ACCOUNT BALANCES’:** After 90 days of no payment the account holder will be referred to a collection agency for payment. Future appointments may be suspended until payment is made.

*I grant my permission to you or your assignee, to telephone me at home, my work, or my cell phone to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing.*

*I have read the above conditions of treatment and payment and agree to the contents.*

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Patient Name (Print) Relationship to Patient if Minor

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Signature Date