

# SMILE SISTERS, LLC

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Pasadena, MD 21122  
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bakersisters.com



## Financial Agreement

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fees for treatment, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and preserve our relationship.

Payment for services is due at the time treatment is rendered. If you have dental insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. We will be happy to process your insurance claims for reimbursement as well as accept insurance assignment from insurances we are participating providers with. Our office is provided with "general benefit" information from your insurance, which is not specific or a guarantee of benefits or payments. If for any reason your insurance denies a claim you will be responsible for the balance.

Your deductible if any and "estimated co-payment" are collected at the time of service. We cannot guarantee exact amounts to be paid by your insurance carrier. If there is any remaining balance after your insurance has processed your claim, the balance is your responsibility.

Missed and broken appointments waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste there will be a charge of \$50 for broken or missed appointments. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 hours in advance or lateness that results in an inability to complete scheduled treatment.

Returned checks due to insufficient funds or closed accounts will have a \$35 charge.

If your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance for collection fees.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: \_\_\_\_\_

Date:

Relationship to Patient:

Response Date: