Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of you insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Patient Information Document. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance to each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. Your **estimated** copayment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. Our practice accepts cash, personal checks, Mastercard, Visa, and Discover. Third party extended payment financing (Care Credit and Citi Health Card) is available upon request and approval.

Returned checks and balances older than sixty days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date