

## Patient Financial Agreement

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality of dental care utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue excellent service to you and minimize our administrative costs.

Payment is due at the time service is provided. Our office accepts cash, checks, MasterCard, and Visa. Additional no-interest financing may be available upon request and approval.

For those of you with dental insurance, as a courtesy, we will assist you in processing your insurance claims. By signing this agreement you direct and authorize your insurance company to pay your benefits directly to our office. In order for our office to file your insurance claim, you must bring your insurance card to each appointment.

Your **ESTIMATED** co-payment amount is due when services are provided.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Our office is not a party to that contract or any possible restrictions.

Balances older than sixty days are subject to additional rebilling fees of \$7.00 per month and collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, charges may be incurred for missed appointments, and appointments cancelled without advance notice. Returned checks will be subject to a \$30.00 processing fee.

The undersigned specifically agrees to pay all reasonable attorneys fees and court cost in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

\_\_\_\_\_  
Sign name

\_\_\_\_\_  
Date