

## ***FINANCIAL AGREEMENT***

Thank you for choosing us as your oral health care provider. We are pleased to have you as a member of the practice.

Our primary goal is to provide our patients with the highest quality dental care available. In addition, we strive to furnish this care at the most reasonable cost possible. One of the ways we contain costs is to reduce the time and expense of billing and submitting insurance claims. To accomplish this we have adopted certain policies concerning payment for treatment rendered.

We view the overall treatment experience as a shared responsibility. Our dental team is absolutely committed to providing the best care available in a prompt, professional, caring manner at a fair cost. Complete customer service is our aim. Because of this, we know we can rely on our patients to respond in kind. Together, we can continue in this mutually beneficial and trusting relationship, while maintaining costs, by adhering to the Financial Agreement.

The following payment options were constructed in conjunction with the accounting department with the purpose of putting quality treatment within the reach of all our patients. We feel a suitable option has been provided to meet each individual need.

Consequently, we believe this will allow us to practice dentistry in a way that truly best serves our patients' needs. Your input is always welcome.

**\*\* Insurance \*\***

We will file your insurance if you provide a completed and signed form yearly. An estimate of your co-payment will be calculated at each appointment. ***You will be responsible for this amount at the time of treatment.*** After the insurance company has paid the claim, you will be responsible for any remaining balance not paid by the insurance company. Please inform the office manager if you have more than one insurance plan, and which of these is your “primary” carrier. We will gladly submit all insurance claims accompanied by x-rays, narratives and/or photographs when appropriate. Despite this, some insurance companies deny payment based on coverage limitations, or delay payment in the name of “request for more information.” ***Refusal of the insurance company to pay for any reason will immediately make the remaining balance the responsibility of the insured.***

**\*\* No Insurance \*\***

***If you do not have dental insurance, payment in full is expected at the time of your appointment.*** (Note: for treatment requiring two or more visits, you may elect to make equal payments over the number of visits for that treatment. Arrangements must be made in advance of the appointment.)

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**..... Payment Options .....**

**CASH or CHECK** Cash or check is the preferred method of payment. A 10% discount will be given when fees are paid in full at the time of treatment.

**CREDIT CARD** We gladly accept Visa, Master Card, American Express and Discover.

**PAYMENT PLANS** Payment plans are available through 0% credit cards at [www.carecredit.com](http://www.carecredit.com)

## *Special Circumstances*

1. Individuals who are 65 or over may be eligible for a 10% discount.
2. In case of divorce or separation, the parent or person accompanying a child is ultimately responsible for charges.
3. Credit balances may be reimbursed to you by check or applied to your next appointment.
4. A returned check will result in a \$25.00 fee being charged to your account.
5. We reserve the right to charge a \$10.00 re-billing fee for all unpaid accounts over 60 days.

This financial policy was constructed for optimal fairness to all involved parties. We appreciate your understanding and cooperation in this regard and welcome any suggestions or comments.

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*Signature of patient/accompanying adult*

*Date*