Patient /Parent name_____ Date of Birth:_____
Dependents: _____ Date of Birth:_____
_____ Date of Birth:_____
_____ Date of Birth:_____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your 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 a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insura company to make sure payment is expected. If payment is not received or your claim is denied, you be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assi the claim being paid. Our office will not, however, enter into a dispute with your insurance compar over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor who has consented to treatment are responsible for full payment at time of service. **Unaccompanied Min** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointment (s) and Cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling yo appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company t pay my dental benefits directly to my dental office. I understand that responsibility for payment for denta services provided in this office for myself or my dependents is mine, due and payable at the time services rendered.

Communications with you: By signing below, you are authorizing us to call you at any number you provic including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charg that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You ag that we may place such calls using an automatic dialing/announcing device. You agree that we may make calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient /Parent name printed_____

Patient /Parent signature _____ **Date** _____