FINANCIAL AGREEMENT

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***In order to provide optimal treatment to your child, we strive to establish financial arrangements with you before any treatment begins.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and Care Credit.

2. As a courtesy, we will file your insurance claims for you.

3. Our office will file your insurance claim a maximum of **two times** per appointment.

4. **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

5. You must provide the office with a dental insurance card with the proper mailing address and phone number of the insurance company. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees, and we will provide you with a claim form for you to submit for reimbursement.

6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and estimated portions at the time of service. **You are responsible for paying all charges not covered by your insurance company. If it is an out-of-network insurance, you are responsible for all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

7. **The office cannot carry balances longer than 90 days;** regardless if the insurance payment is still pending.

8. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

9. There will be a $30.00 service charge for all returned checks.

10. **Should there be a divorce, custody or separation arrangement, the parent or guardian who signs this Financial Agreement is ultimately responsible for any balances owed to our practice.**

AUTHORIZATION

I have read, understand & accept the above Financial Agreement, & agree to the terms set forth regarding payment.

Patient Name: _____

Signature of Responsible Party: _____

Relationship to Patient: _____ Date: _____