FINANCIAL INFORMATION FOR OUR PATIENTS

Thank you for selecting our office to care for your dental needs. For your convenience we have outlined the following financial agreements. Please read them over carefully, and should you have any questions, please don't hesitate to ask.

1. Complete payment at the time of services by Cash, Check, MasterCard Visa, and Discover. We ask that all services be paid at the time of your visit. If you have insurance we will file all the necessary paperwork for you to your insurance company.

2. Dental Insurance: We are pleased that you have insurance, and our office staff "understands" Dental Insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract.

   You must realize, however that:

   a. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract.
   b. Not all dental services are a covered benefit in all contracts.
   c. Regardless of insurance coverage, you are responsible to us for all fees for services rendered to you.
   d. Payment of estimated patient portion is due when services are rendered.

RELATED INFORMATION

1. If your bank for any reason returns a check a $25.00 processing fee will be incurred.
2. If your balance becomes delinquent additional collection fees and interest charges of 1.5% per month, or 18% annually will be applied to the unpaid balance at the end of the month.
3. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees.
4. Your appointment time has been "reserved" exclusively for you. Any change in your appointment, without sufficient notice, affects many patients. We ask that 48 hours notice be provided to avoid a broken appointment charge of $35.00 - $100.00.

I have read and understand the above information. All information provided by me is correct to the best of my knowledge. I understand that when I undertake treatment in this office, I am responsible (regardless of my insurance) for all fees incurred from services rendered.

Date:_____ Patient Signature:_____Staff____