FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. We will make every effort to **estimate** your insurance benefits to the best of our ability and please know that your insurance company **will not** guarantee any payment to us until the claim for payment is submitted. Therefore, we are **unable to guarantee** any **estimate** that we present to you.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the treatment is completed depending upon the final reconciliation of insurance payments.

If you do not have dental insurance you will be given a Treatment Plan Estimate and payment will be due at the time services are provided.

Our office accepts cash, personal checks, Visa, MasterCard, Discover, and American Express.

Returned checks are subject to a service charge.

A late charge of 1.5% will be assessed on balances not paid within 30 days from the time services are provided.

Additionally, we reserve the right to charge you for appointments that you do not keep and for appointments that you do not cancel with 24-hour notice. The charge is $50.00 per appointment.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

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Print Name of Patient or Responsible Party

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Signature Date