Bradshaw Mountain Family Dental

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials 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.

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 an agreement between you, your employer, and the insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance at each appointment.

Your **estimated** co-payment for treatment, which is the amount not assisted by your insurance, is due at the time treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and American Express, Third party; extended payment financing is available upon request and approval.

Returned checks will be assessed a $25 service fee and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1/5% per month (18% annually). **In addition a $30.00 fee will be charged each month until balance paid in full.**

Our practice requires 48 hour notice if you can not keep your scheduled appointment. If you miss three appointments without giving us the required 48 hour notice, you will be requested to find a new provider for you dental needs. If you are 10 minutes late or more for an appointment you may be asked to reschedule or treatment may be altered.

TURN OFF CELL PHONES. Please make arrangements for children if you are having a procedure done at that visit. Please do not hesitate to ask if you have any question regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care

________________________________ Signature of Patient or Responsible Party

________________________________ Print Name of Patient or Responsible Party

Date ____________________

Bradshaw Mountain Family Dental

ASSIGNMENT OF BENEFITS AGREEMENT

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment document that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date