FINANCIAL AGREEMENT

Patient name: _____ Date: _____

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining health service. If your insurance company rejects a claim and refuses to pay for a service, it is not a reflection of how important the service is.

Please note our agreement is with you, NOT your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. *We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits.*

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations:

1. We accept Check, Cash, Money Order, Visa, MasterCard, Discover and American Express.
2. We offer a 5% prepay special discount for all treatment paid for at the time of scheduling.
3. We offer interest free extended payment plans through Care Credit.
4. In-office contract with an extended payment plan (3 installments).

Please note: Our office has a 48 hour cancellation policy. Your appointment is time reserved especially for you as our patient to provide you with outstanding care for your dental care needs. We strive to provide you with a two day courtesy reminder via. e-mail, text or call, however it is ultimately your responsibility to remember your dental appointment. Please take note that there is a $50.00 fee for appointments cancelled with less than 48 hours notice.
To avoid increased fees to all patients, any account balance over 30 days will be assessed a fee of 18% of the balance due. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

Patient's Signature: _____

Date: _____