Financial Agreement

Last Name: _________________________ First Name: _______________________

Date: ______________ Birth date: ____________

1.) For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

2.) Patients without dental insurance, payment in full is expected unless other arrangements have been made in advance.

3.) Patients with dental insurance: Please have a copy of your dental benefits or insurance card available.

A. You are responsible for any balance not covered by your insurance company.

B. You may pay in full at the time of visit with a direct reimbursement sent to you from your dental insurance company.

C. Estimated co-payments and deductibles are due at the time the services are rendered other arrangements are made in advance.

4.) Visa and MasterCard credit cards are accepted. We also offer Care Credit.

5.) If sent to collections, I agree to pay all related fees and court costs.

6.) Treatment plans may change, and I will be responsible for the work actually done.

A FEE OF $50.00 WILL BE ASSESSED FOR FAILED APPOINTMENTS AND FOR APPOINTMENTS CANCELLED WITHOUT A 24 HOUR NOTICE TO THE OFFICE.

**** * * * * * If your account should become delinquent, you agree to pay the costs of collections, including collection agency fees, attorney fees, prejudgment and post-judgment interest and court costs.***

Signature: