EAST VALLEY PERIODONTICS

FINANCIAL AGREEMENT

Name of Patient:_____ Guardian if Patient is a inor:_____

IF YOU HAVE INSURANCE:
When visiting our office for an initial consultation / exam you will be required to pay the portion of our exam fee that is not covered by your insurance. When treatment is rendered, we will collect the estimated patient portion as determined by the information acquired from your insurance carrier. Please be aware that no guarantee of coverage can be given without a pre-authorization from your insurance carrier and any balance due after insurance pays will be your responsibility; including deductibles or any residual amount that insurance did not allow.

This office works hard to ensure that there is appropriate reimbursement from your insurance company for the dental services that are provided. Your insurance company is under contract with you and/or your employer. Should questions arise regarding your benefits, it is advisable for you to contact your insurance company directly. Regardless of insurance benefits, you (the patient) or your responsible party are responsible for ALL charges related to your care. We will provide your insurance with any information that they request, if they do not pay your claim within 90 days from the date of service, you will be sent a bill. Your payment is expected to follow within 30 days. We will promptly reimburse you for any credit balances that result if insurance pays after your bill is settled. If you are of legal age and someone other than your spouse is responsible for the charges, they must be present to sign their acknowledgement of this agreement.

IF YOU DO NOT HAVE INSURANCE:
Payment for services are due at the time services are rendered unless prior arrangements have been made. We accept cash, money order, personal check under $250, debit, Visa, Mastercard, Discover and American Express.

To make treatment more affordable for our patients, we offer no interest payment plans up to 18 months and low interest financing for larger amounts that require longer term financing; through 3 different financial institutions. (Care Credit, Citi Health Card and Spring Stone Patient Financing) This will require an application to be completed by you. We are able to have an answer within minutes. You may also apply at home over the phone or internet.

PAST DUE ACCOUNTS:
Past due accounts over 30 days are subject to interest charges of 1.5% per month, with a minimum finance charge of $5.00 per month. Accounts with insurance pending will not be charged collection fees for the first 90 days. After 90 days, if your claim is not paid, you will be billed for the full amount owing and interest will be charged starting 30 days from the date that your statement is sent out.

Accounts that are past due will assigned to our collection agency, you will be charged a 30% collection fee, you will be charged for the court costs, finance charges incurred and all other related fees.

Checks returned by financial institutions for insufficient funds will be subject to a $25 fee.

Your signature indicates that you understand that you are responsible for all co-pays and deductibles required by your insurance plan; and that you also understand that you are responsible for services that are not covered by your insurance policy. Your insurance is a benefit to you and any unpaid balance after insurance pays is your responsibility.

Your signature acknowledges that you understand and accept the terms outlined above.

Print Name Signature of Responsible Party Date

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