

FINANCIAL ACKNOWLEDGMENT AND AGREEMENT

Printed Name of Patient:

Printed Guardian if Patient is a minor:

IF YOU HAVE INSURANCE:

When visiting our office for an initial consultation / exam you will be required to pay for the exam. We will bill your insurance and apply any credit to your upcoming treatment or send a refund check to you. 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 (even with 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 may 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 <u>prior</u> arrangements have been made. We accept cash, money order, personal check <u>under \$250</u> (*no personal checks over \$250 accepted on the day treatment is rendered*), debit, Visa, Mastercard, Discover and American Express and HSA / FSA cards.

FINANCING:

To make treatment more affordable for our patients, we offer third party, no interest payment plans up to 12 months and low interest financing for larger amounts that require longer term financing through 3 different financial institutions (Alphaeon, Care Credit or Lending Club). This will require an application to be completed by you and approval from the financial company in which you applied for. We are usually able to have an answer within minutes. You may also apply at home over the phone or internet. *Financing must be in place prior to the day services are rendered*.

PAST DUE ACCOUNTS:

Past due accounts over 30 days may be 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 be assigned to our collection agency, you will be charged a 30% collection fee, any court costs, finance charges incurred and all other related fees.

Checks returned by financial institutions for insufficient funds will be subject to an NSF fee as defined by our bank.

Although we do the very best we can to estimate your costs in our office, we NEVER guarantee it will be exact because of the many insurance variables that we cannot possibly account for!

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.

Patient or Guardian Printed Name

Patient or Guardian Signature

Date