Financial Agreement

Patient Name: _____
Date: _____

Total Estimate: _____ **Insurance Estimate:** _____ **Patient Portion Estimate:** _____

Financial Options:

❑ **1. Pre-Payment Courtesy:** We are happy to offer a 5% accounting courtesy for all treatment over $500 that is paid in full, at time of scheduling, or 7 days prior to treatment.

Your Adjustment: $_____ Adjusted Total: $_____ If Paid By: _____

❑ **2. Payment as Services are Rendered:** If you wish to pay the estimated amount for treatment at the time services are rendered, we gladly accept cash, personal checks, as well as MasterCard, Visa, and Discover. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance pays. Whenever choosing this option,

Your next appointment is: _____ At that appointment, you will owe: _____

❑ **3. 1/2 now 1/2 later:** For balances over $500, we offer the option to pay half down at time of scheduling and the remaining half at time of service.

Today's Payment: $_____ Remaining Balance $_____ to be paid on _____

❑ **4. Monthly Payment Plans:**

❑ **Monthly Payment Plan (For amounts $500-$1500):** 6 Monthly Payments that will be automatically withdrawn from your account, with 18% interest.

Half Down: $_____
Remaining Balance: $_____
+ 18 % interest: $_____
= Loan Amount: $_____ Monthly Pmt: $_____

❑ **Extended Monthly Payment Plan (For amounts $1500 and over):** 12 Monthly Payments that will be automatically withdrawn from your account, with 18% interest.

Half Down: $_____
Remaining Balance: $_____
+ 18 % interest: $_____
= Loan Amount: $_____ Monthly Pmt: $_____

❑ **"Lay-Away" Plan:** Treatment commences after monthly pre-payments are made and accrued to equal the estimated patient portion.

_____ By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines.

Appointment Guidelines

Rescheduling Your Appointment:

We pre-plan and prepare for your visit and hope you've done the same. Your appointment has been reserved especially for you.

☐ Should any scheduling changes be required, **we require at least 48 hours advance notice to avoid a $100/hour cancellation fee.**

Courtesy Reminder Calls:

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or text prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, and voice mail, some of our patients may not always receive these reminder calls.

☐ **If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.**

_____ By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

Insurance Guidelines

We are glad you have dental insurance to help you with partial assistance in affording your dental care. Please know that we will do everything possible to see that you receive the full benefits of your insurance policy. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive your full benefits at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- ❑ **Insurance is an agreement between you and your insurance company.** The insurance relationship constitutes an agreement between the insurance carrier, the employer, and the patient. Our dental office is not a party to this contract. As such, we can make no guarantee of estimated coverage or payment.
- ❑ **Full dental fees are not always covered.** Insurance companies base the amounts they pay on restrictive fee schedules, regardless of what the actual fee may be. Our fees are sometimes higher than the average fees allowed by your carrier.
- ❑ **Not all of your care may be covered.** Not all dental services that are necessary for excellent dental health are covered benefits in all contracts. This depends on the kind of plan your employer has purchased.
- ❑ **Deductibles and Co-payments must be collected.** Deductibles and co-payments are built into most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan, its restrictions, and your out-of-pocket expense.

- ❑ **Here's What We Promise To Do:**
  1. Complete insurance claim forms and submit to your carrier within 24 hours of treatment.
  2. Use current American Dental Association coding for correct reporting of procedures.
  3. Accept direct payment from your carrier and keep track of balances.
  4. If necessary, re-file your insurance a second time within a 30-60 day period.

- **Your Responsibilities Will Be To:**
  1. Pay fees not covered by your plan at the time of treatment or as otherwise arranged in advance.
  2. Provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
  3. Understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to force your insurance company to pay.
  4. Pay any account balance not paid by your insurance after 90 days and after 2 billing attempts from our office.

_____ By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines.

I hereby authorize payment of the insurance benefits otherwise payable to me to be made directly to this dental office. I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

Patient ***Date***

_____ _____

Insured, if other than patient ***Date***

_____ _____

Dental Office Representative ***Date***