Patient Financial Agreement

Ideal Dentistry requires all patients to make financial arrangements with us **before** we provide treatment.

1. I understand that full payment is due at the time of service for myself or any of my dependents.
2. I understand that it is solely my responsibility to confirm which treatments, or procedures are covered by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximums).
3. I understand that as courtesy, Ideal Dentistry will attempt to verify my insurance coverage from information that I provide. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.
4. I understand that insurance claims will only be filed if I provide Ideal Dentistry with my social security number and insurance id number. If I choose not to provide Ideal Dentistry with my social security number, I understand that I must pay in full for ALL services rendered. It is Ideal Dentistry's policy to require social security numbers for record keeping purposes even though that may not be the policy of my insurance carrier.
5. I understand that the insurance estimate may differ from what my insurance carrier ultimately pays and that I am responsible for any amounts not paid by my insurance for ANY reason.
6. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridge-work and surgical preparatory work I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund which I may be entitled for discontinued treatment.
7. I understand that all account balances over 30 days may incur an interest charge at the maximum legal rate allowed.
8. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to Ideal Dentistry for payment.
9. I understand that I must inform Ideal Dentistry, in writing, of any concerns, questions, or disputes I may have concerning my treatment or charges in a timely manner.
10. I understand that if I fail to pay my account in a timely manner, Ideal Dentistry may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to, all related reasonable attorney's fees, collection and/or court costs.
11. I understand that unless patient records are sent directly to another provider, the charge for copies for x-rays is $18.00 and treatment information is $5.00 for the maximum amount allowed by law. These fees are subject to change without notice.
12. I understand that Ideal Dentistry currently charges $25.00 for a broken or cancelled appointment without a 24-hour notice. This fee is subject to change without notice.
13. I understand that it is my responsibility to immediately notify Ideal Dentistry of any changes to my address, phone number, work contact information, work status, insurance changes, etc.
14. I authorize payment of the dental benefits otherwise payable to me directly to Ideal Dentistry. I further authorize Ideal Dentistry to deposit checks received on my account when made payable in my name.

I have thoroughly read, understand and agree to the above terms and conditions.

Signature of Patient or Guardian Date

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