Today’s Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

\*This agreement us to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

**Insurance:**

Your insurance coverage is a contract between you and your insurance company. Unless we are a preferred provided for your insurance company, we are not affiliated with this contract. We must emphasize that, as your medical/dental care provided, our relationship is with you, not your insurance company. Unfortunately, not all dental services are considered a covered benefit. Because of our dedication to high standards of dentistry, we will not let the insurance company dictate our quality of care for you.

As a courtesy to you, our office will file your insurance claims for you. However, any applicable patient portion, co-pay and/or unmet deductible shall be collected at the time of service. If there is any remaining balance after the insurance payment, the balance will immediately become the patient’s responsibility. Our office will mail a statement to you reflecting the amount owed. As a return of that courtesy, we would appreciate remittance of the outstanding balance upon receipt of that statement. While we strive to make your dental visits financially reasonable, we also realize that outstanding accounts will have a reflection on our future fee schedule.

**Self-Pay:**

Full Payment is required at the time service is rendered for those who do not have dental insurance. We do offer payment options through outside sources should you require assistance.

**In House Plan:**

 Our In House Discount Plan is an annual DISCOUNT plan. It is your responsibility as the patient to renew this plan one year from the date of initial sign up should you choose to remain enrolled.

**Insufficient Funds:**

A fee of $30.00 will be assessed to your account if the bank renders the check as insufficient.

**Appointment Policy:**

If you cannot keep your appointment, we would sincerely appreciate notification 24 hours prior to your appointment. There will be a fee of $25.00 to the patients account for missed appointments without notice.

I have read and I understand the above.

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_