Douglass Family Dentistry
910-323-8254 (phone)

FINANCIAL AGREEMENT FORM

101 Wall Street
Fayetteville, NC 28301

This is an agreement between Douglass Family Dentistry (Dr. James D Douglass DDS Inc) as a creditor, and the Patient/Debtor.

In this agreement the words "you", "your" and "yours" refer to the Patient/Debtor. The word "account" refers to the account that has been established in your name which charges are made and payments credited. The words "we," "us" and "our" refer to Douglass Family Dentistry.

By executing this agreement, you are agreeing to pay for all services that are rendered and those services rendered in connection to the service.

Monthly Statement: You will receive a monthly statement unless insurance is pending, there is a zero balance or account has been turned over to collections. It will show separately the previous balance, any new charges to the account and any payments or credits applied to your account during the month.

Payment options:

No insurance

Payment is due before services are rendered either by cash, check, debit/credit or care credit card.
Treatment involving laboratory fees for partials, dentures, repairs, crowns or bridges require ½ of your total cost to be paid on the impression date and the remaining balance prior to delivery.

Insurance

You must pay your deductible and any out-of-pocket co-pays before services are rendered either by cash, check, debit/credit or care credit card.
You have the option to pay your bill in full. We will request your insurance carrier send their payment directly to you.
Treatment involving laboratory fees for partials, dentures, repairs, crowns or bridges require ½ of your total cost to be paid on the impression date and the remaining balance prior to delivery.

Missed appointment policy:

Insurance or private pay patients

Appointments that are canceled on the same day of appointment or that you fail to show for are subject to a $25 missed appointment fee.

Medicaid patients

Appointments that are canceled on the same day of appointment or that you fail to show for are subject to a 1st time penalty of 1-month wait for next scheduled appointment and 2nd time penalty of dismissal as a patient at this facility.

I have read both sides/pages of this form and agree to the terms within:

Patient's name: _____

Responsible party
(If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

The Financial Agreement continues on the back side of this page.

Payments: Unless other agreed upon arrangements are made, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

Charges to Account: We reserve the right to cancel your privilege to make charges against your account at any time.

Insurance: Insurance is a contract between you and your insurance company. **YOU ARE RESPONSIBLE FOR ANY AMOUNT DUE AFTER THE INSURANCE REIMBURSEMENT, REGARDLESS OR THE OFFICE ESTIMATE.** Your insurance company will be billed as a courtesy. **WE CAN ONLY ESTIMATE WHAT YOUR INSURANCE COMPANY MAY PAY.** It is the insurance company that makes the final determination for your eligibility. **YOU ARE LIABLE FOR ANY PORTION FO CHARGES NOT COVERED BY YOUR INSURANCE.** If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it and failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Required payments: Co-payments (estimated) required by your insurance company must be paid before service is rendered.

Returned checks: There is a fee [subject to change] for any returned check(s). Post-dated checks are not accepted.

Refunds: If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care you received. In the case of discontinuing treatment with lab cases, you will only be responsible for lab fees and cost of materials. If you have a credit balance at the conclusion of treatment, we will send a statement of credit to the address on file and you may request an immediate refund of any amount due.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this amount due. If your account is referred to a collection agency/ lawyer you are liable for all collection costs and/or fees that are incurred. Any account balance on which payment has not been made for 3 months (from the time of initial statement) may be turned over for collections. Previous unpaid balances must be paid prior to service unless prior arrangements have been made.

Waiver of confidentiality: In general, a health care provider may disclose protected health information as necessary in a legal proceeding without an individual's consent or authorization if disclosure is required by law and the disclosure complies with the requirements of the law.

Divorce: In the event of divorce or legal separation, the party responsible (if not the patient) remains responsible for payment of the account. In the event of a divorce of legal separation, the parent authorizing treatment for a child will be the individual liable for subsequent charges in relation to the rendered services.

Co-signture: If this document is co-signed, those individuals are equally responsible for all services rendered until a subsequent arrangement, if any is rendered with this office. If written cancellation is received, it becomes effective upon receipt in regard to any future services.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect at that time.