Jason Ashcroft DMD, MSD

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Financial Agreement

Please read and initial each of the following:

_____ **Payment:** Payment is expected in full for each appointment as services are rendered. Payment options are:
- Cash
- Check (There is a minimum fee of $32 for every check returned by the bank)
- Credit Card (MasterCard, Visa, and Discover)

_____ **Dental Insurance:** We do participate and accept most PPO plans and Medicaid; however it is your responsibility to confirm with your insurance company that the doctor is under contract with your specific plan. Any deductible, co-pay, non-covered services, and any other charges your insurance does not cover will be your responsibility and paid in full at the time of service.

_____ **Missed Appointment:** Our office courteously requests 1 business day notification if you are unable to keep your scheduled appointment so that we can make arrangements for someone else to fill that spot. Patients with multiple missed appointments may be asked to transfer their records to another doctor.

_____ **Emergency/After Hours Appointment:** If your child has not been previously seen by our office all emergency treatment must be paid in full at the time of service.

_____ **Monthly Statement:** If you have a balance on your account after insurance has paid or denied payment, we will send you a monthly statement. It will show the previous balance, any new charges to the account, finance charge, if any and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

_____ **Finance Charge:** A finance charge will be added to your account for any balance that is unpaid within (60) days of the date of service. The FINANCE CHARGE will be computed at the rate of (1%) per month.

_____ **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

_____ **Divorce/Separation:** In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ **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.

This is an agreement between Pediatric Dentistry of Haslet P.C. and the Patient/Debtor named on this form. In this agreement the words "you," your" and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we," "us," and "our" refer to Pediatric Dentistry of Haslet P.C.

_____
Patient's Name

_____
Parent/Legal Guardian/Responsible Party (Printed)

_____ _____
Parent/Legal Guardian/Responsible Party (Signature) Date