FAMILY DENTAL CENTRE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that your payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications, and also any other services not directly provided by the dentist.

Missed Appointments:
Unless we receive notice of cancellation 48 hours in advance, you will be charged $45.00. Please help us service you better by keeping scheduled appointments.

Insurance:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance pays any portion.

Payment:
Fees for dental services are due at the time services are rendered. If Insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service unless other arrangements have been made. Should your account become delinquent, we will place the account with a collection agency and you will be responsible for collection fees equaling 30% of any unpaid balance placed for collection, as well as interest at the rate of 8% per year. Additionally, if an attorney is engaged to pursue collection of the amount, you will be responsible for all reasonable attorney fees, court costs, sheriff or service of process fees and any other reasonable costs of collection. Please indicate below the form of payment you with to choose.
_____Cash _____Check _____ Credit Card

By signing this Financial Agreement, I have read and understand the above. My signature indicates acknowledgement and agreement of the above.

_____ _____
Signature of patient or Parent requesting care Date