



FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: ____/____/____

We are committed to providing you with the best possible care. If you have insurance, we are available to help you receive your maximum allowable remaining benefits. In order to achieve these goals we need your assistance in obtaining this goal and understanding of our financial/payment policy.

We ask that payment be made at the time service is rendered. For your convenience we accept checks, money orders, cash, debit cards, credit cards and care credit. Care Credit is a healthcare payment program that allows you payment over time and only takes a few minutes to apply at www.carecredit.com. If at any time you have questions regarding your account or treatment, please call us, we are more than happy to assist you in any way we can. Many times, a simple telephone call will clarify any questions or misunderstandings. **Cancellation Policy**, we require **48 hours notice of cancellation**. If for some reason you will be unable to keep your scheduled appointment, please call us as soon as possible and at a minimum of 48 hours prior to your appointment. If you fail to meet this requirement you will be charged a **\$110.00** fee. This fee must be paid prior to being rescheduled with us.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Not all services are a covered benefit in all insurance contracts. Insurance companies differ in their policies regarding coverage of procedures, services that a doctor may provide and coordination with other policies you may have. They may arbitrarily select certain services they will not cover. Depending on your specific policy, (which only you are privy to all the details of), it may require you, as the subscriber, to pay nothing, a deductible, a co-pay/portion of your total costs; or it may require you to pay for the entire procedure/service.
2. We choose not to participate in managed care/PPO/HMO contracts with medical insurances or DMO contracts with dental insurances because we feel it will not allow us to provide the level of care and service that our patients and colleagues have come to expect of us and that we demand of ourselves. However, some of the medical plans allow "out of network" benefits and will reimburse all or a portion of your total out of pocket cost (depending on the details of your policy), in addition to any dental coverage you may have.
3. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. **We must emphasize that our relationship is with you, the patient, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, you are fully responsible for all fees charged by this office regardless of your insurance coverage.** We will do our due diligence to forward all requested information by the insurance company to receive reimbursement, however, in the event we receive denial of any/all fees after submitting all required for reimbursement, you will be responsible for any balance in full and it will be your responsibility to dispute any discrepancies you feel there are regarding reimbursement with your insurance company.

We are happy to offer pre-treatment estimates. **Please be aware that this is an estimate only**, based on findings during your exam and information received from your insurance company, charges may be higher or lower depending on the nature of your procedure/s. Insurance coverage estimates may also vary, being higher or lower depending on deductibles and pending claims that are processed after we review your coverage, also any other treatment you may have already received will reduce the remaining benefits allowed by your insurance contract. The first thing the insurance company states to us when we call requesting your benefits is; "the information given is not a guarantee or authorization of payment." Most insurance companies will process a claim within 4-6 weeks, if you have more than one carrier each company will take that time for processing of your claim. **Any remaining balance after your insurance has paid or denied is your responsibility.** Your prompt remittance is appreciated. In the event your balance is sent to collections you will also be responsible for all fees related to collecting any outstanding balance.

We appreciate the opportunity to care for you. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)

PRINTED NAME

DATE