Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. MasterCard
4. Visa
5. Care Credit / Discover
6. Credit card authorization for recurring charges:
   a. Treatment exceeds $600
   b. Plan may not exceed 6 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment. There is a

$30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 24 HOURS IN ADVANCE.**

I (print name) _____ agree to these financial terms.

Signature: _____ Date:_____

PATIENT

PATIENT LAST NAME FIRST MIDDLE		PREFERRED NAME TO BE CALLED		TODAY'S DATE	☐ MALE ☐ FEMALE
BIRTH DATE M / D / YR	SOCIAL SECURITY NUMBER	HOME PHONE ☐ NONE ☐ MESSAGE PHONE		MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP	
MAILING ADDRESS		CELL PHONE	CITY	STATE	ZIP CODE
HOME ADDRESS ☐ SAME			CITY	STATE	ZIP CODE
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE	ADDRESS		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?					RELATIONSHIP

SELF IF MALE, HUSBAND, OR FATHER OF PATIENT IF APPLICABLE — FINANCIAL RESPONSIBILITY (PLEASE FILL OUT COMPLETELY)

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE			RELATIONSHIP
HOME PHONE ☐ SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS ☐ SAME AS ABOVE		CITY STATE	ZIP CODE
EMPLOYER ☐ SELF ☐ NONE ☐ RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

SELF IF FEMALE, WIFE, OR MOTHER OF PATIENT IF APPLICABLE — FINANCIAL RESPONSIBILITY (PLEASE FILL OUT COMPLETELY)

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE			RELATIONSHIP
HOME PHONE ☐ SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS ☐ SAME AS ABOVE		CITY STATE	ZIP CODE
EMPLOYER ☐ SELF ☐ NONE ☐ RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐ YES ☐ NO	SCHOOL ATTENDING	CITY GRADE	GRADE
BOTH PARENTS NAMES	MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐ Mo ☐Fa FINANCIAL CUSTODY? ☐ Mo ☐ Fa	

PRIMARY DENTAL INSURANCE ☐ NONE ☐ PA, MEDICAID, WELFARE (If None or PA, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		C ITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		

SECONDARY DENTAL INSURANCE ☐ NONE (If None, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		C ITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		

OVER