

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	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
BIRTH DATE M / D / YR	SOCIAL SECURITY NUMBER		HOME PHONE <input type="checkbox"/> NONE <input type="checkbox"/> MESSAGE PHONE		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	
MAILING ADDRESS			CELL PHONE	CITY	STATE	ZIP CODE
HOME ADDRESS <input type="checkbox"/> 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 <input type="checkbox"/> SAME		SOCIAL SECURITY NUMBER		DRIVERS LICENSE NUMBER		STATE
HOME ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY	STATE	ZIP CODE
EMPLOYER <input type="checkbox"/> SELF <input type="checkbox"/> NONE <input type="checkbox"/> 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 <input type="checkbox"/> SAME		SOCIAL SECURITY NUMBER		DRIVERS LICENSE NUMBER		STATE
HOME ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY	STATE	ZIP CODE
EMPLOYER <input type="checkbox"/> SELF <input type="checkbox"/> NONE <input type="checkbox"/> RET		BUSINESS ADDRESS		BUS. PHONE		OCCUPATION

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	SCHOOL ATTENDING	CITY	GRADE
		GRADE	
BOTH PARENTS NAMES		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa FINANCIAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa

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

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	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 <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	

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

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	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 <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	

OVER