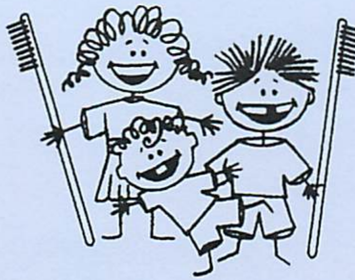

FINANCIAL AGREEMENT

If the patient does not have dental insurance, payment in full is expected on the day of service. If the patient does have dental insurance, the responsible party will pay the **ESTIMATED** portion and deductible on the day of service. The insurance will be billed as a courtesy, however, **please be aware if the insurance does not pay within 60 days payment in full is expected** from the responsible party.

Because it is **your** insurance plan you are ultimately responsible for knowing and executing the requirements of your insurance. We strongly suggest you call your insurance to verify your plan. **No insurance company will guarantee an exact payment.** Please keep in mind that all insurances relay a disclaimer that states they are **only giving general information when** we call to check on your benefits.

We will do everything we can to assist you in obtaining the maximum of your insurance plan. **However, the insurance is a contract between you and your insurance carrier. Therefore you are ultimately responsible for payment in full of your account.**

I understand that insurance companies pay on a usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. I am responsible for the difference between the Doctor's fee, and the insurance fee. **I understand the doctor will be using white filling material; some insurance companies will reduce the fee to a silver filling rate.** It is my responsibility to pay the difference if any between the two fees. I understand that every 6 months my child will have a full exam, x-rays, and a prophylaxis/fluoride treatment. If my insurance does not cover that often, **it is my responsibility to let the staff know before my child goes back for their appointment.** I understand that if my child has been referred by another Dentist my insurance may not cover the cost of the exam, or x-rays due to plan limitations, and it is my responsibility to pay.

When scheduling work with an oral sedation I understand that my insurance **will not** cover this charge. **Sedation fee of $200.00 is due in full along with all estimated dental co-payments on the date of service.**

There will be a **$25 returned check fee** assessed to your account on all returned checks. I agree to pay interest of 18% APR on any account over 60 days late and the cost of any re-billing fee, no-show fee, and certified letter fee. Should your account be turned over for collections, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% APR, late fees, re-billing fees, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

I have read and understand the above policies and agree to abide by them.

SIGNATURE ________________________________ **DATE** ____________________

(parent or legal guardian)