Caring Family Dentistry

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

Please initial below:

- _____ All charges I incur are my responsibility regardless of my insurance coverage.
- _____ I understand that as my dental care provider, your relationship is with me, your patient, not with my insurance company.
- _____ My insurance policy is an agreement between me, my employer, and the insurance company. Caring Family Dentistry is not a part of that agreement.
- _____ If payment is not received from my insurance within 60 days from date of service, I will be expected to pay the balance in full.
- _____ I understand that my **estimated** co-pay is due at the time of service.

As a courtesy to you we will help process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement with your issuance company. In order for our practice to file your insurance claim, you must bring new or updated insurance information to your visits.

Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date