



## FINANCIAL OBLIGATIONS

**METHODS OF PAYMENT:** Cash, Check, Visa, MasterCard, Discover, Care Credit & Lending Club

- 1.) **Broken Appointments:** Your appointment time has been reserved exclusively for you. To avoid a missed or broken appointment charge of **\$57.00**, please contact our office 24 hours prior to your appointment when a change or cancellation is necessary.
- 2.) **Returned Checks:** A **\$30.00** fee will be charged for any check returned by your bank. Subsequently, you have (10) days to make additional payment arrangements. Should your bank return two (2) checks you will only be able to pay by cash, money order or credit card for all future appointments.
- 3.) **Payment:** If you have dental insurance, we will *estimate* your co-payment and ask that you *pay your portion at the time of service*. We will submit your insurance claim to your insurance company for you as a courtesy. If you do not have dental insurance, *payment in full is expected at the time services are rendered*.
- 4.) **Monthly Statements:** Our office generates statements at the end of each month. Each statement will show insurance payments along with any remaining balance due on your part. At that time, you are responsible for payment in full on your account. After 90 days with no payment from you, your account will start accruing **18%** interest and will be turned over to an attorney at which time you will be responsible for all collection fees (including 33.33% attorney fees, court costs, interest, etc.).
- 5.) **Dental Insurance:** We are pleased you have dental insurance. However, your insurance contract is between *YOU and your INSURANCE COMPANY*. The insurance company may pay all, some, or none of your treatment. Not all necessary services are a covered benefit under all dental insurance contracts. *Therefore, you are responsible for the total amount regardless of insurance reimbursement.*

***I have read and understood the above information. I understand that I am ultimately responsible (regardless of my insurance) for any charges incurred from services rendered and for payment of all charges.***

NAME (please print) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_