DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged $45.00. Please help us service you better by keeping scheduled appointments.

Late Arrivals: If you are more than 15 minutes late for your appointment, we ask for your patience in seeing if we can rearrange our schedule to see you. If you think you will be more than 15 minutes late for your appointment, please call us immediately, so that we may advise you if we can rearrange our schedule to still see you, or if we need to reschedule you for a different day. If we must reschedule, a broken/missed appointment fee may be charged based on frequency of this situation and on the services that were being provided to you

INSURANCE: **Please remember your insurance policy is a contract between you and your insurance company.** I certify that the information I have provided regarding my insurance coverage is correct and authorize Dr. Hill's office to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I understand if my insurance company refuses to pay or pays less than estimated, that the dental insurance is designed to offset the costs of my dental treatment and should not be an obstacle to obtain the recommended health services. I agree to pay any payments, co-payments, or deductibles as required by my insurance plan for dental care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

PAYMENT: FULL PAYMENT: is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service, unless other arrangements are made. There will be a fee of $45.00 for a returned check

Balances not paid after 60 days will be considered delinquent and will be sent to our collection agency. Once the account has been placed in collections, the patient or patient's parent/guardian if the patient is a minor, will be responsible for the actual cost of collection.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

_____ _____

Signature of Patient or Legal Guardian Date