



Financial Agreement

Patient Name: _____

Our office believes that part of a successful dental treatment plan is a clear mutual understanding of the costs involved and the payment terms expected. We will make every attempt to let each patient know the costs of treatment prior to beginning dental care with us, however, do be aware that treatment can occasionally change from what was originally planned. Please ask if you are at any point unsure of your financial obligation.

PAYMENT IS DUE ON THE DATE OF SERVICE BY CASH, CHECK, OR MAJOR BANKCARD.

WE REQUIRE SOCIAL SECURITY NUMBERS UNLESS PATIENT PAYS IN FULL AT EACH VISIT REGARDLESS OF INSURANCE COVERAGE.

Our office also offers financing options through CareCredit, a third-party program especially designed for the needs of dental patients. Should you be interested, the financial administrator can review this plan with you and show you how you can apply. This needs to be accomplished prior to scheduling treatment.

Finance charges (18% /APR) are assessed on all account balances over ninety days and are not waived for reasons of untimely insurance settlements. The patient understands that unpaid accounts may be assigned to a credit reporting collection service.

DENTAL INSURANCE

Should you have dental insurance, as a service to you we will file insurance claims on your behalf and we will try to help you estimate what your benefit reimbursement will be. Please be aware that most dental insurance plans are designed to cover primarily only dental health maintenance due to their annual benefit limitations.

Estimated insurance benefits are **ESTIMATES** only and are not a guarantee of coverage. Patients are encouraged to contact their insurance carrier and familiarize themselves with the limits and provisions of their policy. The patient should always bring current insurance information with them to their appointment.

Ultimately, the patient is responsible for timely payment of all dental fees, regardless of coverage limitations. The patient understands that dental insurance is a contract between them and their insurance carrier, and that Dr. Miller is not party to this contract. You will receive a statement monthly even if claims are outstanding. If insurance has not paid within sixty days, the patient agrees to pay the full balance. Any insurance benefits subsequently allowed will be reimbursed to the patient.

MISSED APPOINTMENTS

The doctor reserves appointment times exclusively with each patient. We are committed to being here to serve you and ask that you honor your commitment to us as well. The office reserves the right to charge a missed appointment fee for repeated short notice cancellations.

I hereby authorize the doctor to take radiographs, photos or other diagnostic aids deemed appropriate to make a thorough diagnosis. I give permission for Doctor to share these records with other professionals for teaching/consulting purposes. I authorize Doctor to perform treatments that are indicated.

I have read the financial agreement above and I understand and agree to abide by the terms of this agreement.

Signature of Financially Responsible Party

Date

