

Financial Agreement

Dear Patient,

We welcome you to our family and would like for you to review the policies of our practice that ensure that you and other patients will receive the best possible dental care whether you have dental coverage or are paying for treatment yourself.

Because we are committed to providing you with the best care, we recommend treatment based on what is most beneficial for the patient and not based on insurance limitations. Your dental benefits are based upon a contract between your employer and an insurance company. Your employer ultimately decides how limited your benefits are. We believe that the patient, and not their dental insurance, should ultimately make the decision regarding their treatment. Please keep in mind that dental insurance is only meant to assist you in paying for your dental treatment and by no means provides a comprehensive solution. If you have any questions regarding your benefits please contact your employer or insurance company directly prior to treatment.

The patient is financially responsible for all treatment charges resulting from patient responsibility (co-payments), deductibles, and any other charges not covered by their insurance. As treatment progresses, the fees may have to be adjusted due to changes in the treatment plan or complications. We will make an effort to keep you informed of these changes prior to continued treatment. Please understand that estimates and prior authorizations are not a guarantee of payment and are provided as a courtesy of planned charges.

The patient/guardian hereby authorizes and assigns all payments, for services rendered, to be directly payable by the dental insurance company, including Medicaid, to the offices of Alliance Dental P.C. **In rare cases the patient may receive the check for treatment performed by our office. If this happens the patient must sign and bring the original check or make a payment to our office within 7 days of receipt, or finance charges will be applied to the account.**

The patient must inform Alliance Dental P.C. of any changes to the insurance policy, including termination of coverage, prior to continued treatment. If you have been seen at another dental office, other than Alliance Dental P.C., **you must notify us** or you may incur unexpected charges.

Eligibility is verified as a courtesy and does not guarantee payment. Any charges resulting from changes to the insurance coverage or due to termination of coverage are the sole responsibility of the patient and are due within 30 days of initial invoice.

The patient/guardian agrees to pay the outstanding balance to Alliance Dental P.C by the last day of treatment unless other arrangements are made beforehand. If the outstanding balance is not paid in full by the last date of treatment, Alliance Dental P.C. reserves the right to charge a late fee of \$25 per month until the balance is paid out in full. Finance charges will apply to all unpaid balances. Alliance Dental P.C., at their discretion, may forward all invoices with an outstanding balance to the credit bureau and/or collection services. If such a situation should arise, the patient/guardian will be responsible for a collection charge and late fees that will be applied to the account.

We will bill your insurance within 7 days of treatment, and will re-bill your insurance up to 2 additional times as a courtesy if necessary. If the insurance does not issue payment within 90 days of treatment, Alliance Dental P.C. reserves the right to request the payment in full from the patient or legal guardian, and let the patient collect the insurance funds that are due. You are ultimately responsible for all charges incurred in our facility.

It is important that the patient does not miss their scheduled appointment as a specific amount of time is allotted per patient. Any cancellation or lateness disrupts our schedule and affects our ability to provide the necessary amount of attention to our patients. Any patient that misses an appointment without providing our office with 24 hours notice of cancellation, will be billed a cancellation fee of \$75 for every 30 minutes of allotted time.

I (the patient/guardian) hereby understand and agree to honor the rules and the financial agreement outlined above

Printed Name:

Patient Signature

DATE