Financial Agreement

Last Name: _____ First Name: _____

Birthdate: _____ Today's Date: _____

Please understand that payment of your bill is considered part of your treatment. All payments are due at the time of service. For patients who carry dental insurance, we will help prepare your insurance forms or assist in making collections from insurance companies. However, we cannot render services on the assumption that our charges will be paid by your insurance company. You, as the patient, understand that all dental services furnished will be charged directly to the patient and that he or she is personally responsible for payment of all dental services not covered by your insurance company. Patients also acknowledge that all co-pays are estimated. Both co-pays and deductibles are due prior to treatment. If there is a remaining balance after your estimated co-pays and insurance payments, you will be responsible for the balance. We have made payments easier by offering 3,6,12,18 and 24 month interest free payment plans through Care Credit. Extended payment plans are also available. Any legal costs due as a result of attempting to collect fees owed by patient, will become your sole responsibility to pay. If your account balances become past due, we will take the necessary steps to collect this debt. Id we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

Signature: _____