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2016

Financial Responsibility

My signature on this form indicates that I am financially responsible for my dental care and the dental care of my spouse and dependent minors. I also understand the limitations of dental insurance and that any estimates of benefits given are just that, an estimate and that ultimately, I am responsible for the fees set forth and discussed in the treatment for myself and my dependents regardless of insurance benefits promised by my insurance carrier.

1. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates or my account is not paid in full within 60 days, I understand that a 1 1/2% finance charge may be added to my account on the 5th of each month, in addition to any collection fees or bank charges that may apply. A \$46.00 charge will also be added for any checks returned by the bank for insufficient funds. If your account has to be sent to collections for non-payment, an \$90 collection and credit reporting charge is applied to your account. I understand that any insurance charges and co-payments are my responsibility at the time care is provided. Charges and fees will increase slightly each year.

2. I understand the late cancellation policy at your office. Since the staff do not double book the doctors or hygienists time, patients who cancel less than 24 hours in advance (not including weekends or holidays), or do not show for an appointment, are charged a late cancellation fee of **\$102.00 per 30 minutes of appointment scheduled.** We would be glad to reschedule your appointment at a more convenient time if you allow us 24-48 hours notice.

3. I understand that the long-term success of my treatment depends on personal oral hygiene, completion of recommended dental therapy, regular recall and dental care appointments, overall general health and a sincere commitment to maintain oral health.

Credit Report Authorization:

In the event that credit needs to be extended to the patient by this dental office, it will be necessary for a credit report to be run to evaluate the credit worthiness and risk of extending credit to the patient.

Signature _____

Date _____