EAST 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 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:
There may be a fee for appointments broken without 24 hours' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. Please help us service you better by keeping scheduled appointments.

INSURANCE:
As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. However, your insurance company makes final determination once treatment is completed and the claim is submitted. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you**. Your insurance is a contract between you and your insurance company/employer; therefore, all charges are your responsibility. We are not a party to that contract. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

For those without insurance, please ask about discounts for paying the day of services rendered. There is a new Military discount this year and we've lowered the senior discount for those who are 50 years and older.

PAYMENT:
We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options: Cash, Money Orders, Check, Visa, MasterCard, Discover and American Express.
Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.
It is your responsibility to notify us if there is any insurance problems with payment. Unpaid balance over 90 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

*Patient's Name:*_____

Signature of Patient or Parent/Guardian If Minor:

_____*Date:*_____