

FINANCIAL AGREEMENT

For

Dr. Susan Smith

Dr. Deepa Assandas

Thank you for choosing us for your dental care. Payment for services are due when the services are rendered. Your deductible and co-payments are required by your insurance. We will try to give you the most accurate cost estimate possible, from the information given to us by your insurance company. We accept cash, checks, and major credit cards.

As a courtesy to our patients with dental insurance, we will be happy to file your primary insurance claims for you, but you are ultimately responsible for all costs of treatment incurred. We do not bill secondary insurance. Please understand your insurance is a contract between you, your employer, and the insurance company. Not all of our services are covered benefits by your insurance company. Patients with dental insurance must provide us with current dental information, such as the name of the dental insurance company, telephone number, address, group number, proof of coverage with an insurance card or identification card. At the time of your first visit, we will try to contact your insurance company to verify coverage and check your co-pay and deductible amounts. If your insurance does not pay in full within 30 days, we ask that you contact your insurance company. If your insurance does not pay in full within 60 days, we will require you to pay the balance in full.

As a courtesy to our patients, we provide appointment reminders. These can be calls, texts and/or emails, please let our front office know which you prefer. If no preference is indicated, our standard email or text will be sent. It is the patient's responsibility to keep their appointments. We understand that unexpected changes may arise, if this occurs we request 24 hour notice for changed appointments. To keep our office running smoothly, appointments changed with less than 24 hour notice will incur a fee of \$100 per hour of Doctor's time, and \$55 per hygiene visit.

I understand that I am ultimately responsible to pay for all services rendered, in the case of a default the cost of attorney's fees, court costs, and the cost of collection proceedings. Returned checks are subject to returned check fee and any bank charges which are incurred by us.

I have read the above conditions of treatment and payment and agree to their content.

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Signature of patient, parent or guardian

Date