FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth_____

PAYMENTS:

The estimate of fees by our office in your **treatment plan** is to be considered as a conservative guideline. There may be moderate increases or decreases in the fees, depending on your treatment needs. Payment for charges is due at the time of service. **One third of CO PAYMENT is required in ADVANCE, PRIOR to the procedure being scheduled, for ALL major dental treatment (crown, bridge, partial or full dentures) fabricated by a laboratory and oral surgery.** The forms of payment we accept include: **Visa, MasterCard, Discover, American Express, Debit Card, Personal Check with valid ID or cash.**

DENTAL INSURANCE:

Dental insurance information must be provided to our office for determination of coverage and benefits. Our acceptance does not absolve the responsibility for charges for treatment rendered. Insurance is a contract between your employer, the insurance company and you, our patient. **Most dental benefits do not cover the full cost of care.** Any unpaid portion is the patient's responsibility, due upon receipt of the insurance explanation of benefits or our billing statement. Many insurance plans have exclusions, limitations and alternate benefits that are set by your insurance company and make the proper processing of your insurance claim confusing and difficult. As a courtesy for patients with insurance benefits, we will collect our **best estimate** of your portion of the current charges (including any applicable co-payments and/or deductible) for that day's service. We calculate your co-payments according to the information we gather from your insurance company. We take great pride in helping you receive the **maximum benefit** from your insurance carrier. Our office makes every effort to be accurate in our estimation of benefits by calling your insurance company to verify eligibility, coverage and benefits. However, since there is no way to be sure benefits have not been used in other offices, or that the policy is in effect at the time of service, **our office can make no guarantee of the insurance payment as estimated.** Please address any questions regarding the explanation of benefits to your insurance carrier(s) or employer's plan administrator. Claims are submitted promptly after treatment is rendered. If your insurance hasn't paid 45 days of submitted charges, the charges will be considered your responsibility and payment in full is expected from the responsible party. **FULL PAYMENT is required of copayments, PRIOR to the completion of any procedure labeled by your insurance company as MAJOR treatment (crown, bridge, inlay, onlay, partial or full denture). FULL PAYMENT at the doctor's private practice fee schedule is required in ADVANCE, PRIOR to the procedure or evaluation, when your insurance benefits cannot be verified such as emergency after hours visits.** When your insurance benefits are verified, a claim will be processed and any credit will be applied to your account for future treatment.

BILLING:

All accounts are to be paid in full within 30 days of treatment regardless of insurance benefits. In the event an account becomes over 90 days delinquent, I understand that **Dr. Schimon** will refer my account to small claims court. If this action is necessary, I agree to pay all additional collection fees, in addition to my account balance. It is my responsibility to follow up with my insurance to make sure payment has been made to **Dr. Schimon** in a timely fashion. I also understand additional late fees of $3.00 plus 1.5% per billing cycle may be applied if my payment is not received within 15 days of the statement. **There is a minimum $35 fee added to all returned checks.** Account credits will remain on account for future treatment.

APPOINTMENT POLICY:

Our **private practice** is growing as many new patients are discovering our attention to detail and compassionate care. Therefore, **scheduled appointments are specifically reserved for you.** We will help remind you of your appointment by contacting your preferred telephone number on record to confirm a scheduled appointment, 24 hours in advance. If we do not speak with you directly, we will leave a voicemail reminder. We will charge $35 for all failed scheduled appointments.

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the undersigned, in consideration for services rendered to the patient by **Dr. Schimon**, have read, understand and agree to the terms f this ***Financial Agreement.*** All of my questions and concerns have been satisfactorily answered and addresses.

atient's Signature:_____ **Date:** _____

Ultimate Family Dental
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