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 your financial policy which we require that you read and sign prior to any 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.

CONFIRMED APPOINTMENTS:
We do our part in making sure you are aware of your pending future appointments. Unless we receive confirmation in advance of 24 hours, your reserved appointment will be given to another patient.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate and filing insurance claims, which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for services, It is your responsibility to have these questions answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:
FULL PAYMENT is due at time of services. If insurance benefits apply. **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

Please indicate below the form of payment you wish to choose.

( ) Cash or Check
( ) Visa, MasterCard, Discover
( ) If you qualify, a monthly payment plan is available for your convenience

Unpaid balance over 90 days 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 recovery of the monies due on the account.

The parties agree that in the event of a dispute over any payment or fee due to Plateau Family Dentistry by the undersigned, the Circuit Court of Cumberland County shall have exclusive jurisdiction and venue for any litigation filed.

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature_____ **Date**_____