PEARL DENTAL

FINANCIAL AGREEMENT

We are committed to providing you with the highest level of professional service and quality care. The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our office team.
We will communicate all recommended treatement options and ***estimated*** cost of associated fees, prior to start of treatment. **Payment is expected at the time of treatment.**

It is the Patient's/Parent's/Legal Guardian's responsibility to:

- Provide our office with current address, phone numbers and employer.
- You must be prepared to pay your copay or outstanding balance due at each visit. We accept cash, check and all major credit cards.
- We offer CareCredit, a third-party company to offer the flexbility of 6 month or 12 month interest free financing and extended payment options allowing smaller monthly payments.
- A service charge of $30.00 will be assessed on all returned checks.
- The patient/guarantor is responsible for **all fees** associated with the collection of an outstanding balance that has been sent to the collection agency. These fees will be added to your account.
- We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed will be subject to a missed appointment fee of **$50**. Should you find it necessary to reschedule an appointment, please provide us with a notice of **two business days** to avoid being charged a missed appointment fee.

*I**mportant facts about your dental insurance:***

- Be familiar with the benefits and limitations of your plan, including copays, coinsurances and deductibles. ***Bring all of your current insurance cards to all visits***.
- As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. Our office participates with most major insurance plans. We **DO NOT** participate with **ALL** dental plans.
- **Dental insurance is a contract between the patient and the insurance company.** It is a benefit to assist you with the cost of dental care. **At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.**
- You (not the insurance company) are responsible for the fees of services rendered.

By signing below, I acknowledge that I have read and understand the above Financial Policy. I understand and agree I am financially responsible for all charges for services rendered. I hereby assign all insurance benefits to which I am entitled to Pearl Dental. I authorize the use of this signature on all insurance claims. I authorize Pearl Dental to release all information necessary to secure payment of benefits.

Printed Name of Patient____

Patient Social Security #(mandatory)____

Patient Date of Birth____

Signature of Patient/Parent/Guardian____

Printed Name of Parent/Guardian____

Today's Date:____

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