FINANCIAL AGREEMENT

In order to avoid any misunderstanding regarding our financial policy, it is necessary for you to read and sign this document before treatment.

DENTAL INSURANCE: As a courtesy we will gladly file your claims provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
- If we are not a preferred provider of your insurance you are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" fees. We will be happy to provide a dental claim to expedite your reimbursement.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. If your insurance fails to pay within 60 days, you will be responsible for the balance on your account.
- Not all the services we provide are covered benefits. Benefits differ by dental plan. Fees for non-covered services along with deductibles and copayments are due at the time of service.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

PAYMENT POLICY: We accept cash, personal checks, and credit cards. If a check is used it must be the patient's account and be signed by the patient. Third party checks are not accepted.

RETURNED CHECKS: A $75.00 charge will be applied when a check is returned by the bank. Non-payment checks not reconciled will be sent to the State Attorney's office.

CANCELLATION POLICY: A fee of $100.00 will be applied if an appointment is cancelled or broken without at 24 hour notice. We reserve the right not to make future appointments if this occurs more than twice. This fee is subject to change without notice.

RECORD COPIES: A nominal fee (as noted by the Florida Dental Practice Act) of $20.00 for copies of all radiographs and $10.00 for the first 10 pages of clinical notes is due. Our office has 30 days to release all necessary information.

I have read, understand and agree to this Financial Policy.

Patient Signature Printed Name Date

Responsible Party Signature Printed Name Date