FINANCIAL AGREEMENT

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatments affordable to all or four patients. Please review the following policies and procedures:

PAYMENT POLICY: **Payment is due at the time services are rendered. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit. We kindly ask that you leave photo identification and a valid credit card which will be kept on file in your record for payments that need to be made to your account.**

1. We accept cash, personal checks with proper ID, money orders, Debit Cards, Visa, MasterCard, Discover, and AMEX.
2. If there is a balance and the charges have been on the account for over 90 days, you will be required to pay Premier Endodontics LLC an 18% (per annum) finance charge per month on the unpaid balance until paid in full.
3. You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees, and/or attorney fees).
4. Financing is available through Care Credit with prior approval.
5. Fees will apply for any check that is returned by the bank.
6. MINOR PATIENTS: In the case of divorced or separated parents, it is YOUR responsibility to have financial arrangements made according the divorce decree before treatment begins.

DENTAL INSURANCE: **As a courtesy we will grandly file your claims and accept assignment of dental insurance benefits provided you agree to the following:**

1. You must provide us with any insurance card and/or all of the information necessary to verify your coverage and file your claim.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
3. You are responsible to pay our fees; not what your insurance company allows or considers “usual, customary, and reasonable” (UCR), all of which vary from one company to another.
4. Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
5. All charges not paid by your insurance company are your responsi8bility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.
6. Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
7. There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out of pocket expense will be.
8. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

BROKEN OR MISSED APPOINTMENTS: **To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of $50.00 (fee based on appointment length and/or number of appointments missed). Missed or broken appointments prevent others from receiving the dental care they deserve.**

1. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understand this document in its entirety; outlining the office and financial policies of Premier Endodontics LLC and agree to these terms.

Signature of patient or parent/guardian: _____ Date:_____