GEORGE FAMILY DENTISTRY
FINANCIAL AGREEMENT

Thank you for choosing George Family Dentistry for your dental health needs.

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full, so we would like to explain our financial option. Please choose the option that works best for you.

1. **Payment is due at the time treatment is rendered.** We accept Cash, Check, Master Card, Visa, Discover and CareCredit.
    a. We offer a 5% accounting courtesy for all treatment that is **paid in full** (cash or check) at the time of service.
2. Dental Insurance – As a courtesy to you we will submit your services to the insurance company. Your **estimated** co-payment (the amount not covered by your insurance) for treatment is **due at the time treatment is provided**.
    a. If you fail to bring the required insurance information to your appointment we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.
    b. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for any and all remaining balance. _____ **Initial**
    c. Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.
    d. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company, you or your employer. We have no control over this relationship.
3. Monthly payment options – If you need to make long-term payments we can offer financing with CareCredit which offers up to 12 months NO INTEREST financing as well as longer terms with low interest rates. You must qualify for this option.
4. Minor Patients – The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid. _____ **Initial**
5. Statements –All patients with an outstanding balance will receive a statement each month. A finance charge of 1.5% per month (18% per year) will be added to all balances over 60 days overdue. All accounts over 90 days are subject to our collection agency.
6. Returned checks -- A fee of $25.00 will charged for any returned checks.

7. Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointment. If you must change your appointment, we require **at least a 24 hour notice** to avoid a **$25 cancellation fee** (emergencies are an exception).

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collection agency or legal fees and any other charges incurred to collect this account.

Thank you for giving us the opportunity to serve your dental needs.

---------- ----------

Print Name of Patient or Responsible Party Date

Signature of Patient or Responsible Party