Preston
DENTAL CARE PLLC

Financial Agreement

October 26, 2017

To our patients: We are pleased you have placed your trust in us to care for your dental needs. We look at this as a privilege and a responsibility. We will strive to fulfill to the best of our abilities your dental and financial needs. This agreement is part of our commitment to work with you on the financial aspects regarding the care you receive at our office. The following is provided to avoid any misunderstanding or disagreement concerning payment for services rendered at our office.

TO OUR PATIENTS WITH INSURANCE

1. As a courtesy, we agree to do the initial billing to your insurance company. If you have secondary insurance and want us to file the claim, that information *must* be given at the initial visit.
2. Co-payments will be collected at the time services are rendered.
3. Your insurance coverage is an agreement *between you and your carrier*. It is your responsibility to remit payment for services not covered. If a payment is sent directly to you from your insurance company, it will need to be forwarded immediately to us.
4. Any un-paid balances left by your insurance company will be your responsibility.
5. If insurance payments are not received within 30 days from the date of services, we will follow-up with your insurance company to see why the claim has not been processed or why a denial was received.
6. It is your responsibility to provide us and/or insurance company with all new information regarding any changes in your dental insurance-new cards, new coverage, discontinued coverage, etc.
7. Any outstanding claims over 90 days will be closed and payment will be your responsibility.

TO OUR PRIVATE PAY PATIENTS

1. We accept cash, checks, and debit cards, Visa, MasterCard, Discover, American Express and Care Credit.
2. Payment is expected at the time of service. If needed, in advance to your treatment appointments, an approved payment plan can be established. That payment plan will be through Care Credit, an out of office credit company.
3. A 5% discount is offered as a courtesy to our patients who pay their balance in full by cash or check at time of service.

Billing statements and accounts

1. If the balance due is not paid in full with the first billing, a $2.00 billing fee will be charged for each billing cycle.
2. A $25.00 service charge will be applied for all returned checks. Unpaid returned checks will be forwarded to Magistrate Court.
3. Any accounts over 120 days will be sent to a collection agency and the family will be dismissed from our practice.

Appointments

We will call or text as a courtesy to remind patients of their scheduled appointments. To ensure we can reach you, please update all telephone numbers. We ask if any appointment must be cancelled, that we are given at least 24 hours notice so we may offer that appointment to a patient on our waiting list. Multiple cancellations of less than the 24 hours notice or broken appointments for a family may result in a dismissal from our practice.

I, the undersigned, hereby confirm that I have read and understand this Financial Agreement given to me by Preston Dental Care, PLLC. I hereby confirm my responsibility for services rendered by this office e and I understand that any attempt to collect from my insurance is strictly a courtesy to me. In the event that the services rendered are not covered or paid by my insurance within 90 days, the account is solely my responsibility.

Signature of patient or guardian _____ Date_____