Dental and Cosmetic Solutions
Financial Agreement

Payment: Payment is due at the time services are rendered. We accept the following forms of payment: Cash, Checks, Master Card, Visa, American Express and Care Credit. Outstanding bills will be subject to billing/finances charges. [Initial]_____

Dental Benefit Plans: Your dental benefit is a contract between you, or your employer, and the dental plan. Benefits and payments received are based on the terms of the contract negotiated. We are happy to help our patients with dental benefit plans to understand their coverage, but we cannot guarantee the accuracy of information received from the insurance company or any changes regarding that contract. [Initial]_____

If we are a contracted provider with your plan, you are responsible for the approved fee as determined by your plan. We are required to collect the patient's estimated portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at the time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this, and you will be responsible for paying the difference. [Initial]_____

If we are not a contracted provider with your dental benefit plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. ***IF*** your plan allows reimbursement for services, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance you are responsible, and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan, even if that amount is different than our estimated patient portion of the bill. ***IF*** you choose not to "assign benefits" to our practice, you are responsible for filing the claim and obtaining reimbursement, and will be responsible for payment-in-full to our practice before, or at the time of service. [Initial]_____

Scheduling appointments: We reserve time in our schedule for each patient procedure so when a patient cancels an appointment, it impacts the number of patients we are able to care for each day. To maintain the utmost service for all our patients, we do require 48hour notice to cancel or reschedule an appointment. With less than 48-hour notice, a fee will be charged. If there are more than two short notice cancellations in a 12 month period, we will no longer be able to reserve an advanced appointment for you. We do understand emergencies arise, and ask that you notify us as soon as possible. [Initial]_____

Authorizations:

I authorize the team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment discussions. (Initial) _____

I authorize the release of information necessary to process my dental benefit claim and I authorize payment to be made directly to Dental and Cosmetic Solutions for services rendered to me (Initial) _____

Signature of responsible party: _____ Date: _____