PROUD TO SERVE FAMILY DENTISTRY
FINANCIAL POLICY

Assignment and Release

I the undersigned, have insurance with _____, and assign directly Proud to Serve Family Dentistry all benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether paid by insurance or not**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

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

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Proud to Serve Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor within **90 days**, I am responsible for the total amount(s).

I understand that there will be a $50 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least **48 hours/2 business days** prior to my scheduled appointment time. ***I understand that a cancellation fee of $80 per hour of reserved time may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.***

Treatment appointments will require a deposit of either 1/2 the fee for the appointment or $150 (whichever is the lesser) to reserve that time.

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that all treatment payment is due in full at the time of service. I understand that **after 60 days, any unpaid balance will incur a $10 billing fee**. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

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

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. ***I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment.*** A receipt will be provided so I may seek reimbursement.

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