Financial Responsibility Agreement and Consent for Services

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to providing you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

We are not contracted with any insurance companies so patients are responsible for the copayment as well as mailing the check to us when necessary.

Insurance:
Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

1. Filling insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimates and pre-estimates are *not a guarantee* from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company. We are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally accept assignment of benefits (payment) from your insurance company, but we reserve the right to refuse assignment. In that case, full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. In the event that you wish to have us invoice your insurance directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Fantastic Family Dental.

Payment policies:
As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our patients for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. We will discuss financial options with you before rendering treatment.
By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement, including the following:

1. Payment is *due in full at time of service* unless prior written financial arrangements have been made.
2. There is a $35 service charge on all returned checks.
3. We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24 hours notice.
4. I understand and agree that any account balance not paid within 90 days will be subject to collection activity. I understand that Fantastic Family Dental may retain the services of an attorney to assist with the collection of any outstanding balance.
5. I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Fantastic Family Dental.

Print Patient Name: _____Signature: _____

Guarantor Signature: _____ Date: _____/_____/_____