



### **Agreements, Authorizations, and Signature on File**

We value our relationship with our patients and will be happy to assist you regarding our office policies. If you have dental insurance, please make sure you provide the most current dental insurance card to our front office. We file claims as a courtesy for our patients. We are In-Network Providers with Delta Dental PPO, Delta Dental Legion, Cigna DPPO, SunLife Financial, United Healthcare: PPO Standard Network & National Medicare Network, Lincoln Financial, select UMR plans, select Guardian DentalGuard Preferred Select, United Concordia Elite Plus, and DenteMax Plus/ AlwaysCare: Unum, Colonial Life, Starmount, AlwaysCare.

We do not accept Aflac, Medicare supplemental plans (other than United Healthcare), Medicaid, or any plans which do not allow our office to file claims on behalf of the patient. Most plans pay between 40-50% of average dental treatment fees. The percentage paid is determined by how much you or your employer have contracted with the insurance carrier. We do our best to give you the most accurate estimate of your portion. We, at no time, guarantee what your insurance will or will not cover with each claim. **You are responsible for your estimated fees and deductible at the time services are rendered, as well as any balance that may remain after your insurance payments are received.**

If your insurance plan does not take assignment of benefits, you will be required to pay for the entire balance at the time of service.

If your insurance company has not paid on your account within 90 days, you are responsible for the balance of your account unless specific arrangements have been made prior to dental treatment.

If you do not have dental insurance, full payment is required at the time services are rendered.

For your convenience, we accept cash, check, Care Credit, and all major credit cards.

**A \$35.00 fee is charged for all NSF/returned/ stopped payment checks.**

**A charge of \$25.00 will be applied for broken or missed appointments unless 24 hour notice is given to our office.**

\_\_\_\_\_ I understand and agree to a 10% finance fee for accounts 90 days overdue, with a minimum finance fee of \$5.00. Should my account be referred for Collection services, I am responsible for all fees incurred including the 50% Collection Service fee, any legal fees, attorney fees, and other such costs as the Court determines proper.

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Patient or Legal Guardian Signature

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Date