

-updated January 12, 2026

Financial Agreement

Name: _____

DOB: _____

We sincerely appreciate the privilege of serving you and your family and remain committed to upholding the highest standards of dental care. To ensure the continued delivery of exceptional service, please take a moment to review and sign our office policies.

Please note: Payment for service, including deductible and copayments, are due at the time of service. For your convenience we accept cash, checks, and debit with no processing fee. Credit cards are accepted, however they do incur a 3% standard processing fee.

- An additional fee of \$25 will be applied for returned checks.
- A finance charge will apply to balances over 30 days at a rate of 1.5% per month.
- Payment plans and financial arrangements are available for extensive comprehensive dental treatment.
- Deposits may be required when scheduling treatment.
 - All lab related treatment requires a minimum of 50% payment at the time of preparation. The balance can be paid at the time of delivery.
- If sent to collections, you will be responsible for all related fees.

Insurance patients:

- All treatment plans are an *ESTIMATE* based on insurance provided information. Coverage is subject to maximums, limitations, exclusions, waiting periods, frequency, deductibles, and age restrictions. Final coverage is determined when payment has been processed by the insurance company.
 - *Your insurance policy constitutes a contractual agreement between you and your insurance party; our office is not an included party in this contract. Ultimately, all charges incurred are your responsibility regardless of the extent of your insurance coverage.*
- In the case that you have an out-of-network policy that mandates assignment of benefits to the patient, payments will be due in full on the day of service and the insurance company will mail you the check of benefits.
- We process and file all your dental insurance claims as a courtesy.
- If there are insurance delays over 30 days, we may ask for your involvement to get payment. If the claim is over 60 days, we may ask for payment of services in full.

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Missed or cancelled appointments:

Appointments are reserved exclusively for you, and our goal is to provide treatment for all our patients in a timely manner with as few appointments as necessary.

- We require a 24-hour notice for cancellation of your appointment. If an appointment is not cancelled at least 24 hours in advance, or if you fail to keep the appointment, you will be charged \$50 per hour for missed appointments. (i.e \$100 for 2 hours, \$150 for 3 hours, etc)
- These fees will not be covered by your insurance.
- Multiple failed appointments or cancellations without appropriate notice may result in dismissal from the practice.

I have read, understood and agree to the above terms and conditions. I authorize the dental company to pay my dental benefits directly to my dental office whenever possible. I understand that I am fully responsible for payment for dental services provided in this office for myself and/or my dependents.

Signature: _____

Date: _____