



300 W. Boyd Drive, Allen, TX 75013 □ 972-727-3941

## Financial Agreement

Our office works with most dental insurances. We are considered **out of network**. Some policies do not allow for out of network coverage. As a courtesy our office accepts assignment of your primary insurance benefits so that you will not be out of pocket for the full amount of service. Our office will estimate your primary insurance benefits for each visit. We can generally estimate your benefits with reasonable accuracy; however, you will be held fully responsible for any amount not paid by insurance regardless of the reason they refuse payment. Insurance often does not pay as much as expected or may refuse payment for certain procedures based on your policy provisions. Waiting periods and other clauses/exclusions will also affect your coverage. Please note your insurance policy is an agreement between yourself, your employer and the insurance company. Please know that we will do everything possible to see that you receive the full benefits of your primary policy. Your estimated portion is due and payable in full at the time of your visit. We do not accept assignment of benefits for secondary/supplemental insurance coverage and secondary benefits will not be considered when figuring out of pocket expenses for services. If you require financial assistance in planning for your portion of the bill, please make arrangements with our office prior to your scheduled treatment date. If for any reason your insurance company has not paid their portion within 45 days of your date of service, you may be asked to pay the balance in full at that time.

Notice to Delta Dental Patients: As mentioned above, our office is considered an out of network provider. The majority of Delta Policies will only make payment to the policy subscriber (patient) when an out of network dentist is seen. For this reason, our office requires Delta policyholders (our patients) to make payment in full at time of service. As a courtesy, we will file your claims to Delta for reimbursement to you.

We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care you need and want with respect to your budget. Our office accepts Checks, Cash, Visa, MasterCard, Discover, American Express and CareCredit®. CareCredit® is a service offered by GE Capital Consumer Card Company that currently offers low or no interest monthly payment plans. Please let us know if you are interested in more information about CareCredit®. A \$35 service charge will be assessed on all returned checks.

As a courtesy our office extends the following discounts to our patients that qualify. For our patients 65 and older we extend a 10% Senior Citizens discount on all services paid in full at time of service. For all patients our office extends a 5% "in full" discount when services exceed \$500 in one visit and the total of those services is paid in full at the time of service. Cash discounts will not be extended to patients utilizing our assignment of benefits on their insurance. Only one discount may be applied per person per visit.

In order for our office to properly manage your dental care needs current information is imperative. Please help our office keep your records up to date by informing us of any changes to your account. This would include but not be limited to: name, address, phone numbers, email address, employer, insurance and all medical/health history.

Our office reserves the right to charge a \$25.00 broken appointment fee. A broken appointment is one that is no showed or cancelled/rescheduled without 24 hours notice. Please remember scheduled appointments are time reserved especially for you. Your 24-hour notice allows us to offer your time to other patients awaiting treatment.

I have read the above conditions and have had an opportunity to have my questions answered. I understand that by signing this document, I agree to all the terms contained within it.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (s)

*We would be happy to provide you with a copy of this financial agreement for your records, upon request.*