FLORENCE FAMILY DENTAL, PC - FINANCIAL AGREEMENT

Thank you for choosing our office as your dental health provider. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. Please understand that your bill is considered as part of your treatment. The following is our Financial Agreement which we require you to read and sign prior to any treatment.

Payment - Payment of **estimated** patient portion is due at the time of treatment. We accept the following forms of payment: Cash, Check, Visa/Mastercard, Discover, American Express, Care Credit. Dentures, partial dentures, crowns, bridges, retainers, or night guards that are to be fabricated by a dental laboratory require a 50% deposit at the time of the first impressions. The remaining balance is due at the time the prosthesis is cemented or inserted. Checks that are returned to our office by your financial institution are subject to a $75.00 returned check fee. This fee covers the processing fees that are charged to our office.

Insurance - As a courtesy to you, we will gladly process your insurance claim forms. We understand that insurance guidelines can be difficult to understand and be overwhelming at times. Using the information provided by you and your insurance company, we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company. Therefore, all charges are you responsibility. All insurance deductibles and co-pays must be paid at the time of service. In the event that your insurance company has not paid your account in full, the balance may be transferred to your account.

Appointments - Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment, so we ask that you kindly give us 24 hours' notice. Without this notice, we are unable to offer treatment to other patients who may have needed our care. Broken appointments and frequent late cancellations are subject to a $45.00 fee. Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the Florence Family Dental, PC Financial Agreement. I understand and agree to this Financial Agreement.

Signature of Patient or Responsible Party:

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Date: ______________________________