Advanced
DENTAL CARE

Financial Agreement and Authorization for Treatment

Patient's Name:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment at the time treatment is rendered. I understand that if I have dental insurance, the office will estimate my possible benefit for treatment and require that I pay for the portion not covered by the insurance at the time of treatment. I understand that any other financial arrangements have to be made prior to any treatment rendered and agreed upon in writing.

As a courtesy and help to me, the office will make every effort to assist me in getting the maximum benefit available but will not guarantee any estimated coverage. Upon acceptance of treatment I will be accepting the office fees and committing to the total amount of treatment regardless of any insurance benefits. The office will honor the fees quoted for 6 months if I accept the treatment plan within 30 days of the consultation appointment. Charges shown by statements shall be promptly paid in full upon receipt. All charges shown are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I understand that a rebilling fee of 1.5% or a minimum rebilling fee of $3.00 will be charged monthly on the unpaid balance. I am informed that if my account is more that 90 days past due, or it will be turned over to a collection agent. Any charges incurred to collect the balance on my account, which include collection agency fees, billing fees, court costs and attorney fees, will be added to my unpaid balance due to be paid by my family or me.

A $25.00 fee will be charged for any personal check returned for insufficient funds. If I fail to keep my scheduled appointment a broken appointment fee of $50.00 per hour will be charged directly to me. I will agree to give 48 hours notice for any appointments that I need to reschedule or cancel or I will be charged $50.00 per hour.

CASH, CHECKS, VISA, MASTERCARD & DISCOVER ARE ALL ACCEPTED

(A copy of this assignment is as valid as the original)

(Signature of responsible person) **(Date)**