Financial Agreement

We appreciate you coming in for an orthodontic consultation. We wish to attract families to our practice that take an active role in their oral health and remain financially responsible. Since we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications on methods payment and insurance reimbursement.

If you have dental insurance to help with your payments, please bring your insurance card to all appointments and notify us of any changes.

As a courtesy, we will file insurance benefits on your behalf. Most insurance companies will pay our office directly, however, some insurance companies may only reimburse the subscriber. If the insurance company does not reimburse our office, you will be responsible for billed services. It is not a guarantee that the insurance company will reimburse for services rendered.

Any amount determined not to be covered by your insurance company is payable at the time the services are rendered. These fees may include:

- Deductibles
- Co-payments
- Fees for procedures not covered by your insurance policy
- Method of payment: *Cash, Debit / Credit Card, Checks, Care Credit, Flexible Spending*

Financing Programs- To help provide cost-effective care, we offer several long and short term financing programs for dental treatment. Please inquire about these programs.

Financial Obligations- Our office does NOT send statements. Monthly payments are due prior to the month's last business day to avoid late fees. Attempts to collect outstanding balances within 60 days that are not successful will be sent to collections.

Prior to beginning any treatment, we will provide you with an estimate indicating the total treatment fee, estimated insurance, if applicable, and the estimated financial obligation due on the day of service including the breakdown of monthly payments..

If orthodontic records are taken and it is decided to not move forward with treatment, a records fee of $500.00 will be due.

I have read and understand the above.

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Signature of Patient/Parent or Guardian **Date**

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Patient's Name