LIVE LIFE SMILING FAMILY DENTISTRY FINANCIAL AGREEMENT

Please read and sign the following information regarding your responsibility for services rendered at our office.

We will file insurance for our patients; however, account **balances are ultimately your responsibility**. Please note that while **most** routine exams and cleanings are covered at 100%, that is **not always** the case. Any part not covered by insurance will be billed to you, the insured. On all services rendered besides exams and cleanings, you are responsible to pay a **minimum** of 20% at the time of service (unless otherwise specified on your treatment plan). All services that we provide that we know insurance will not cover are payable in full at the time of service.

If you do not have insurance, payment in full for professional services is expected at your appointment. For your convenience, we offer our patients a Dental Savings Program** as well as payment in the following forms:

- Cash or personal check
- Visa, MasterCard or Discover
- Care Credit*

*Please ask us for information regarding Care Credit if you would like financing.

**Non-insured patients, please ask us about our Dental Savings Plan.

Accounts that become 90 past due are subject to a monthly 1.5% finance charge. If you should ever be sent to a collection service, please be aware that all your information ***will be shared*** with that company in order to process our claim.

Please note that the parent who initiates treatment and signs this policy is responsible for their child's account, regardless of marital status or divorce settlement. We are not able to bill third party for any amount owed.

If you have insurance, please give a current copy of your card to one of our team members. Please be sure to let us know when you have any changes in coverage. We look forward to working with you to reach a healthy and beautiful smile!

I have read and understand this policy and agree to pay all fees charged to my account.

Signature:_____Date:_____