**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**

We charge a 1½% monthly finance charge on all accounts with a balance 60 day old.
Payment is due in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ CASH ☐ PERSONAL CHECK ☐ INSURANCE CO-PAY

☐ CREDIT CARD (VISA, MC., AMEX, DISC)

*A COPY OF THE OFFICE CREDIT POLICY IS AVAILABLE AT THE FRONT DESK UPON REQUEST.*

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Thank you for your cooperation. If there is any other information of any kind which you feel would be of value to us in your dental treatment, please add such information.

I authorize treatment of the child. I agree to pay all fees and charges for such treatment.

SIGNATURE _____ Date _____

Financial arrangements for dental treatment can be made with our office prior to the commencement of treatment. As a courtesy to our patients, we will be happy to complete and file insurance forms relative to dental treatment. However our professional services are rendered to you, not to the insurance company. Our fees for services are the same for all patients, whether or not they have a dental insurance program. Your particular program may base its allowance on a fee schedule which may or may not coincide with our office fees. **PLEASE REMEMBER THE FINANCIAL OBLIGATION FOR DENTAL TREATMENT IS BETWEEN YOU AND THIS OFFICE AND IS NOT DEPENDENT UPON INSURANCE.**

**AUTHORIZATION AND RELEASE:**

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I AUTHORIZE AND REQUEST MY DENTIST TO USE *SIGNATURE ON FILE* FOR MY SIGNATURE ON ALL DENTAL INSURANCE FORMS TO EXPEDITE COMPUTER PROCESSING OF MY CLAIMS.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

IF I DO NOT PAY THE ENTIRE BALANCE WITHIN 60 DAYS OF THE MONTHLY BILLING DATE, A LATE CHARGE OF 1.5% ON THE BALANCE THEN UNPAID AND OWED WILL BE ASSESSED EACH MONTH. I REALIZE THAT FAILURE TO KEEP THIS ACCOUNT CURRENT MAY RESULT IN YOU BEING UNABLE TO PROVIDE ADDITIONAL DENTAL SERVICES, EXCEPT FOR DENTAL EMERGENCIES OR WHERE THERE IS PREPAYMENT FOR ADDITIONAL SERVICES. IN THE CASE OF DEFAULT ON PAYMENT OF THIS ACCOUNT, I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS ACCOUNT OR ANY FUTURE OUTSTANDING ACCOUNT BALANCES.

PARENTS WHO WISH TO BE WITH THEIR CHILD DURING TREATMENT MUST FIRST CONFER WITH ONE OF THE DOCTORS. WE WILL TREAT YOUR CHILD AS WE WOULD OUR OWN.

X _____

SIGNATURE OF PARENT OR GUARDIAN OF MINOR DATE

REVIEWED BY: DATE _____

STAFF MEMBER'S SIGNATURE _____