

OFFICE FINANCIAL POLICY

Date:	Office:	Patient:
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We are happy you have chosen Professional Dental as your dental provider. We accept many different insurances to benefit our patients. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care, to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that it is their responsibility to provide correct/updated insurance information. All dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services. Professional Dental is happy to submit insurance forms and help resolve outstanding claims to the insurance company designated by you. You must understand that not all insurance companies pay in full for estimated services rendered. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to terms listed above.

I accept Professional Dental Office Financial Policy: **{{acceptfinancialpolicy}}**

Signature

Full Name

Relation to patient

Date