Patient Financial Agreement

James R. Davis, D.D.S.

*Our accountants require all patients to make financial arrangements with this office before we provide treatment. To confirm your understanding and agreement with our policies, please read the following:

Payment- I understand that full payment is due at the time of service including emergency visits or at the initiation of service under a treatment plan for myself or any of my dependents. My payment options are:

- **Cash**
- **Check**
- **Major credit cards**
- **Care Credit**

Further, if I qualify, a financing program may be available through a financial institution that our practice has a relationship with. I understand that this practice has no obligation to provide me or my dependents financing for services that this practice renders. I understand that any and all account balances over 30 days will incur a monthly interest charge at the maximum legal rate allowed. I understand that if a check or any electronic authorization or debit sent or provided to this dental practice for payment is not honored upon first presentment, regardless of the reason, even if the check or electronic authorization is later honored, I will be charged a service charge of $25. I understand that I have the right to dispute charges on my account and agree in good faith to resolve such disputed charges with this dental practice. To the extent that I am unable to resolve such matters directly with this dental practice, I agree to pursue resolution through an informal mediation process with a mutually agreeable independent third party rather than through civil litigation. I undertstand that if my account is not paid in 90 days, this dental practice may report such untimely payments to credit rating service bureaus, refer my account to a collection agency and take legal action against me in order to receive full payment for services performed on myself or any of my dependents. I agree to pay all related reasonable attorney's fees, collection and/or court costs, and a monthly interest charge on my outstanding account balance at the maximum rate permitted by law.

Insurance- In the event that this dental practice is able to verify that I or any of my dependents have insurance coverage from information that I provide, I understand that I will still be required to pay, in full, the portion of the balance that is not covered by my insurance company. I understand that estimates of my insurance may differ from the actual payments made by my insurance carrier and that I am responsible for any amounts not paid by my insurance for any reason. I understand that this practice is billing my insurance company, as a courtesy to me, the patient. I also understand that I or my employer have a contract with my insurance company, and that this dental practice is just a provider of care and has no obligations to collect money for me and will not be expected to be put in the middle of any dispute in regards to the financial dental benefits from my insurance carrier. Any disputes will be my soul responsibility since the

contract for benefits is betweeen myself and the insurance carrier not with this dental practice. I further understand that the extent of coverage depends on the plan that I or my employer has purchased. I realize that it is solely my responsiblity and not the responsibility of this dental practice to confirm which treatments or procedures are covered by my insurance. Also the extent of this coverage including any applicable exclusions or deductibles or annual or lifetime maximums in my policy. I understand that I am responsible for the amount of the benefit allowed by my insurance carrier's usual and customary fee schedule.
I understand that all insurance claims from treatment that I receive at this dental practice are being filed by this dental office with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand this dental practice will submit a claim with my insurance carrier up to 2 times per appointment and that any further insurance appeal is solely my responsibilty. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance for any reason, including but not limited to, my insurance company denying coverage for any procedure, policy deductibles, policy maximums (annual or lifetime) and this dental practice not receiving payment within 60 days of the procedure, even if I am appealing my insurance companys denial of insurance benefits.

Discontinuing Treatment- I understand that if I opt to discontinue treatment for a procedure I previously requested this dental practice to perform, I will be responsible for paying all lab related costs for material and services that were provided for my benefit prior to my desicion to discontinue such treatment and that all such costs will be deducted from any refund that I may be entitled to as a result of any pre-payments for the requested service.

Transfering/Picking up Records- I understand that unless patient records are sent directly to another provider the charge for copies of x-rays and treatment information is $15. Furthermore, I understand that if there is a balance unmet on my or any of my dependents accounts that I will have to satisfy the balance in full before any records can be sent to another provider or copied for me to pick up.

Broken Appointments- I understand that this dental practice reserves the right to charge a fee of $25 for any appoinment that I do not keep or do not cancel at least 24 hours in advance. After two broken or missed appoinments, this dental practice retains the right to discontinue elective treatment and to dismiss me from the practice.

_____________________________________ ________________
Signature of Patient
Date

_____________________________________ ________________
Signature of Guardian Responsible for Patient
Date