

FINANCIAL AGREEMENT

Thank you for choosing Clarity Dental to provide your dental care. We consider it an honor to have been chosen by you to do so.

Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our business office staff

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or consider "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, debit cards, Visa, and MasterCard.
- If the insurance company does not pay in full within 45 days, it will be your responsibility to pay the balance due within 2 weeks.

PATIENTS WITHOUT INSURANCE CONVERAGE

We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS

A \$35.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES

- Finance charges will be applied to all balances not paid within 25 days of the monthly billing date.
- A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid.
- It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges.
- You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
- We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS

Appointments not kept or changed with less than 2 business days' notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

MISSED APPOINTMENTT FEE IF 2 BUSINESS DAYS NOTICE NOT GIVEN

To reschedule or cancel an appointment, you must notify us at least 2 business days in advance to avoid a missed appointment fee of \$65. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

CONSENT & AUTHORIZATION

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Hala Salama DDS of Clarity Dental. Without any reservations, I agree to abide by the policies outlined herein.

FORM COMPLETED BY:

Full name: _____

Signature: _____

IN CASE OF A CHILD:

Relationship to child: _____ Date: _____
(mm/dd/yyyy)

Are you the person legally responsible for this child? Yes No

Reviewed by staff member: _____

Date: _____
(mm/dd/yyyy)