FINANCIAL AGREEMENT
Miller Family Dentistry

Patient Name _____ Date: _____

Dental treatment is an excellent investment in an individual's medical and psychological wellbeing. Financial considerations should not be an obstacle to obtaining health service. We offer the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations.

1. We accept Check, Cash, Money Order, Visa, Mastercard, Discover and American Express.
2. We offer a 5% prepay special discount for all treatment paid for at the time of scheduling when using the above payments.
3. We offer **interest free** extended payment plans of 6 months through Care Credit for qualified applicants.

Dental Insurance:

While we are happy to assist you by submitting insurance claims to your insurance company, please note our agreement is with YOU, and NOT your insurance company. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship and cannot enter into a dispute with your insurance company. You must remember that dental insurance is designed to offset the costs of your dental treatment. Our office staff will help you to the best of our ability, to obtain your maximum benefits, but you are responsible for the cost of your treatment and any insurance reimbursement conflicts**.** You must provide us with current insurance card/ information at each visit in order for our office to submit your claim for you. ***We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits***.

Statements

To avoid increased fees to all patients, any account balance over 30 days will be assessed a $10 rebilling fee every billing cycle afterward. All accounts over 90 days will be notified in writing of their account being transferred to a collections agency.

Returned Checks

A fee of $45.00 will be charged for any returned checks

Broken Appointments

Your appointment time is reserved especially for you as our patient to provide you with outstanding care for your dental care needs. We strive to provide you with a two day courtesy reminder via email, text or call, however it is your responsibility to remember your dental appointments. Please take note that there is a $60.00 fee for appointments cancelled with less than 48-hour notice.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Miller Family Dentistry to process credit card transactions initiated by me by phone and I authorize my credit institution to pay.

_____ _____

Print Name of Patient or Responsible Party Date

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Signature of Patient or Responsible Party