

## DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing **Sutton Dentistry** as your dental care provider. We are committed to your treatment being successful. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

### General:

As a condition of your treatment by this office, payment is required at the time of service unless previous financial arrangements have been made.

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

### MISSED APPOINTMENTS:

Unless we received notice of cancellation 24 hours in advance, you will be charged \$50.00. Please help us service you better by keeping scheduled appointments.

### INSURANCE:

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. This office is out of network with all dental insurance and it is impossible for us to have knowledge and keep track of every aspect of your insurance.

### PAYMENT:

Full payment is due at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made. There are some instances where insurance is on a very low fee schedule and we are unable to determine insurance co-payments. In this case, payment will be due in full at time of service.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of the billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to call, text and/or email me at home, cell or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Patient Name Date: \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Signature of patient/parent/guardian or responsible party

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