Fine Art of Family Dentistry, PA

Financial, Insurance & Practice Privacy Agreement

Financial Agreement

Options for Payment of Services (Payment is due at time of service rendered)

1) Cash or check* with a 5% bookkeeping reduction if paid at the initial visit for treatment over $300. (We use Mastercheck for returned checks)
2) Credit Card * (Mastercard, Visa, American Express or Discover Card) Monthly Credit Card Authorization is an option
3) No Interest * Payment Plans from CareCredit (subject to credit approval)

*Previous responsible party balances must be paid in full prior to receiving additional services, except in the case of an emergency.

*Responsible party is defined as the recipient of care in the case of one individual, one person designated to handle financial arrangements in a family; or in a blended family, the individual primarily involved in bringing the child to appointments and scheduling additional appointments.

Patients with Dental Insurance

1) Extensive treatment will require preauthorization and you will be responsible for paying your estimated portion at the time of service.
2) Previous responsible party balances must be paid in full prior to receiving additional services, except in the case of an emergency.
3) We accept dental insurance assignments, with the understanding that any uninsured portion that is not covered by your dental plan is to be paid by you at the time of service. Your dental insurance coverage is based on the policy or contract you have. Depending on you specific policy, your dental insurance plan may not cover fully on our office dental fees for services rendered. **Please remember the ultimate financial responsibility is yours.**

In the unlikely event that your balance does not get paid, your account will be turned over to a collection lawyer, conciliation court or collection agency.

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the doctor or other healthcare professionals to perform diagnostic procedures and treatment as may be necessary for proper oral care. I authorize the Fine Art of Family Dentistry, PA to release any information (via mail, fax or electronic) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such dental care to third party payers and other entities and/or health practitioners. HIPAA Notice of Privacy Practices has been made available to patient and/or guarantor.

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Patient Name Date signed

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Signature of Responsible Party

This copy of signature is valid as the original. Signature on file is valid indefinitely