**Financial Agreement and Office Policy**

Please review the following carefully, then sign and date the bottom of this agreement once you have reviewed it and understand it fully.

**Payment is due at the time dental treatment is performed**

* We accept Cash, Check, Visa, MasterCard, Discover and Care Credit.
* If you have dental insurance, as a courtesy to you, we will submit your insurance claim for processing. We will estimate your insurance carriers portion and the guarantors portion due by you at the time of service. Should your insurance carrier pay less than the estimated amount, you will be billed for that balance and it will be payable upon your receipt.
* Financing options are available through CareCredit and must be secured in advance of treatment. You can also apply for CareCredit on line at carecredit.com.

Appointment Scheduling is a critical part of our day. With that in mind, we require at least 24 hour notice to cancel / move a scheduled appointment. We make every effort to provide reminders for our patients so they are informed of the next appointment they have scheduled. Cancellations or missed appointments without the 24 hour notice will be charged a $75.00 appointment fee. **Initial \_\_\_\_\_**

By signing this agreement you understand and agree to the policies of this office. Further more you understand that we do our best to estimate treatment and its cost and that final treatment is determined upon the completion of dental work. Insurance benefits can only be **ESTIMATED**. A written pre-estimate/authorization of dental benefits from your insurance carrier is not a guarantee of payment.

Prairie Dental Group is **NOT** responsible for the collection of dental insurance benefits but the claims will be sent as a courtesy to the patient. We make every attempt to ensure the accuracy of your dental claim based on the information provided by each patient. It is the patients’ responsibility to update carrier information, as changes become necessary. You understand that all costs not paid by your insurance carrier are the responsibility of the guarantor and due within 30 days. A finance charge of 1.5% per month will be added to all accounts over 60 days regardless of insurance coverage. I agree to pay that finance charge.

In that event that legal or collection action becomes necessary, I further agree to pay ALL legal, collection and/or court costs involved.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_