Patient Care Agreement

Our primary goal is to provide you with exceptional oral health care. In our office, we strive to maximize your insurance benefits and make payment options straightforward so we can focus on providing you with quality care. Our fees are based on the quality of dental materials we use and the time, effort and skill required required for your needed treatment. We will be sensitive to your financial circumstances; ultimately, however, you are responsible for payment regardless of any insurance benefits.

Please Initial On Each Line

_____ If you have dental benefits we are happy to submit the claims for you. However, coverage is not guaranteed. Your dental benefits are an agreement between you and your benefit company and you will be responsible for all treatment fees.

_____ **Payment is expected on the day of treatment.** If you have dental benefits, we will collect your 65% of the procedure fees. We accept the following forms of payment: cash, check, credit/debit cards (Visa, MasterCard, American Express and Discover).

_____ In addition we offer CareCredit, a patient payment program offering a full range of no interest and extended payment plans for treatment.

_____ **Rescheduling Appointments** We realize that your time is valuable. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments prevents other patients from opportunities. If you find that you must change your appointment, we require a minimum of a 48 hour notice so that we may make every effort to accommodate other patients. If proper notice is not received, a reservation fee may be required to schedule any future appointments.

_____ **Reservation Fee** Our team wants to make certain that you receive the best care possible. For appointments that require 2 or more hours we ask for a reservation fee. This is for the doctor to be able to spend uninterrupted time with you for your appointment. This amount is non-refundable, but will be applied towards your treatment.

_____ **If Applicable-** My son or daughter is a dependent and is 18 years or older or is under 18 years of age. I understand and accept full responsibility for all charges or payments due.

Name of Responsible Party (Please Print)_____

We thank you for trusting us with your dental health care! We are proud to consider you part of our smile family.

I have read and agree to the above Patient Care Agreement.

Name of Patient (Please Print) **Date**

_____ _____

Signature of Patient or Responsible Party

_____