ENDODONTIC ASSOCIATES
DENTAL GROUP

FINANCIAL AGREEMENT

The primary objective of this office is to provide you with the best quality dental care available. This document serves as an agreement between Endodontic Associates Dental Group, and you, the patient/legal guardian. Our objective is to provide comprehensive information in order to alleviate any misunderstandings with regard to our financial agreements.

Patient Financial Liability

Private Pay Patients – You are responsible for full payment of consultation and treatment fees at the time of service.

Insurance Patients – Acceptance of insurance assignments by this office does not **absolve you of full responsibility for charges** for the treatment rendered. **We require a down payment of 30% of the total fees for treatment rendered at the time of service. This down payment does not absolve you of responsibility for the remaining balance after insurance has paid its portion.**

The estimate provided by this office is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled. If only a consultation is necessary, we may require payment regardless of insurance involvement.

Patient initials _____

Collections Agreement

If necessary, we have your authorization to release a minimum amount of your patient information to collection agency(ies) to obtain payment of unpaid balances on your patient account.

Patient initials _____

Returned Credit Card / ACH Payments, NSF Checks, Broken Appointments

There will be a **$25 fee assessed for any form of returned payment**, such as stop payments on credit cards and/or checks, "non-sufficient funds" check returns, and/or returned payment arrangements.

We ask your consideration in calling if you are unable to make an appointment. If an appointment is broken with less than 24 hours notice, **an additional fee of $75.00 will be charged**.

Patient initials _____

Patient Signature_____ Date _____

Endondontic Associates Staff Signature_____ Date _____