DENTAL PARTNERS OF SOUTHWEST GEORGIA
FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

As a courtesy to you we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance to each appointment. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing, such as Care credit and Citibank Health Card, is available upon request and approval.

Direct Reimbursement/Non-Assignment of Benefits- Payment in full is collected at the time of each visit from the patient. Our practice will still complete any necessary paperwork and will send it directly to the insurance company for your reimbursement. Since the patient is reimbursed directly, as the insurance will NOT pay the provider and will only reimburse the policyholder, you are required to pay in full at the time of service

Emergency Patients- Payment is expected at the time of service. We will file your insurance as a courtesy. Once you are a patient of record, then we will just require your co-payment portion.

Minors with Divorced Parents- The parent *who brings the child is responsible* for paying the co-pay or full fee. You will be responsible for getting reimbursed from the other parent.

NSF/Returned checks- There will be a $30.00 fee for processing a returned check. We reserve the right to reject check payment once a returned check occurs.

Missed Appointment- Our practice will charge you $50.00 for hygiene appointments and $75.00 for doctors' appointments that you do not keep and for appointments that you do not cancel with 48-hours' notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party **Date**