FINANCIAL AGREEMENT WITH JUSTIN BEASLEY, D.D.S.

We are committed to providing you the best possible care. To eliminate any misunderstanding regarding the financial responsibility for treatment in our office, the guidelines for payment are as follows:

- **PAYMENT OPTIONS:**

Payment-in-full is due at the time of service or treatment initiation. Payment may be made by cash, check, or credit card. We accept Visa, Master Card, Discover, or American Express. Our office utilizes CareCredit for in-office payment plans. For minors with divorced patients, the responsible party will be the parent who accompanies the minor at their appointment.

- **UTILIZING DENTAL INSURANCE:**

Our professional services are rendered to you, the patient, and not to the insurance company. **Our office diagnoses treatment based on your dental health, not your insurance coverage.** Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. Due to constantly changing insurance contracts, benefits, and deductibles, we are only able to approximate your insurance coverage. We *CANNOT* guarantee estimated co-pays or even if your insurance carrier will make *any* benefit payments for services rendered in our office. As a courtesy to you, we will file your insurance claim at no additional charge. If our office is considered out of network for your plan, we are still able to bill your insurance and receive benefits. At your request, a pre-treatment estimate can be filed to determine your portion due at the time of treatment. If the insurance company pays less than expected, you will be charged the difference. If we haven't received payment from your insurance carrier, *including secondary insurance*, after 90 days, we will charge the balance back to you. Final responsibility for payment rests with the person responsible for your account. We strongly urge you to be familiar with your dental insurance booklet, coverage, deductibles and exclusions in your policy. **We must emphasize that as a dental provider, our relationship is with you, the patient, and not your insurance company.**

- **PAST DUE BALANCES**

Outstanding account balances over 60 days will be charged a finance charge with a minimum of $1.00 or 1% on the balance, beginning from the date of service. Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $25 fee.

- **MISSED OR BROKEN APPOINTMENTS**

Our goal is to keep an efficient schedule so that patients can be seen on time with minimal interruptions. To consistently provide this, we require that you give our office 24 hours' notice in the event that you need to reschedule your appointment. This allows for other patients in need of treatment to use your reserved appointment time. For your convenience, we are requesting that all patients leave a method of payment on file. If you are unable to give 24 hours' notice to cancel or reschedule your appointment, a fee of $50.00 will be applied to your account; this fee will be your direct responsibility. Patients who consistently fail to keep their reserved appointment time will need to place a reservation deposit to reschedule their appointment.

Credit Card: ____Visa ____ Mastercard ____ American Express ____ Discover ____ CareCredit

Name on Card: _____ Billing Zip Code:_____

Card # _____ Expiration Date _____CV2 Code_____

Cardholder Signature: _____ Date:_____

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Check all that apply:

____ I would like any remaining balance after insurance claims have been processed to be applied to this card.
Balances under $_____ do not need to be preapproved

____ I do not wish to leave a credit card on file. I understand that any past due balance may result in pre-payment in full and/or a reservation deposit to schedule any future appointments.

Patient or Guardian Signature Date