



FINANCIAL AGREEMENT AND INITIAL DISCLOSURE

The undersigned patient or Responsible Party agrees that the following terms will govern the payment of professional services rendered by the doctors and charged to the patient's account:

Payment for service is expected at each visit. This includes deductibles, percentages, and treatment not covered by insurance. Patients are responsible for paying all charges not covered by their insurance plans, including all fees considered above their insurance policy's usual and customary fee schedule. The following methods of payment are accepted: cash, check, Visa, MasterCard, and American Express. Application forms for long-term financing are available at the front desk. Please allow at least one week to determine your financial options once all necessary information has been received.

As a courtesy to our patients, we file insurance claims if benefits have been assigned to our office. The coverage a patient receives is determined by the plan purchased by his/her employer, not the fees of the doctor. **Patients are responsible for the TOTAL COST OF TREATMENT regardless of their insurance benefits and payments.** Patients must provide the office with accurate insurance billing information at the time of their appointment, or they will be responsible for payment in full.

Patients with flex-plan benefits must pay for services at the time of visit. We will provide a receipt for reimbursement.

New patient **emergency** visits must be paid in full at the time of service. We will provide an insurance claim form for insurance filing.

The parent or legal guardian who brings the child for their visit is responsible for payment. Regardless of a divorce decree, payment of the entire patient portion is expected at the time of visit. Parents must work out financial arrangements between themselves prior to appointments. Billing statements will not be sent.

Young Dentistry for Children reserves the right to charge a **\$50.00** appointment deposit when rescheduling patients that cancel or fail appointments without a 24 hour notice.

A service charge of **\$25** will be assessed for all returned checks.

Patients may avoid a finance charge by paying the **New Balance** on their account in full within 60 days of treatment completed. Balances over 60 days accrue a 1 ½% PER MONTH finance charge. After 90 days, we will attempt to notify patients that their accounts are delinquent before the practice takes collection action.

In the event that legal action is required as a result of Responsible Party's failure to pay dental fees due under this agreement, Patient or Responsible Party agrees to pay 100% of all collection costs, attorney fees, and court costs incurred by this office to collect said fees and costs from Responsible Party. Doctors may refuse to render future services until outstanding balances have been paid in full.

The undersigned patient or Responsible Party acknowledges that he/she has read, understands and agrees to the information printed above and that he/she may receive a copy upon request.

Patient or Responsible Party: _____ Date: _____