NOVA Dental Anesthesia

OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation **48 hours** in advance, you will be charged **$75.00**. Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether your insurance company pays any portion.

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

***Must indicate below the form of payment you wish to choose**.

( ) Cash or check

( ) Visa, MasterCard, Discover, American Express, Chase, or other major credit card

Unpaid balance over 60 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history. I have read, understand and agree to the terms and conditions of this Financial Agreement.

Print Patient Full Name: _____

Signature: _____ Date:_____/_____/_____
(Patient or Parent/Guardian if Patient is a minor)

Print Parent/Guardian Name if Patient is Minor: _____

Relationship to patient: _____