Financial Agreement

Fenton Family Dentistry's goal is to help you establish excellent oral health. We are committed to helping you determine the most appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence, or fees for services, please ask for clarification before treatment has begun.

Our financial policy is as follows:

- We accept cash, personal checks, and most major credit cards including MasterCard, VISA, and Discover.
- A $35.00 fee will be applied for ALL returned checks.
- Payment is due at the time of service.
- Payment plans for certain procedures are available through CareCredit with payment options available for up to 5 years at fixed rates.
- Insurance- insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. As a courtesy, we will be happy to assist you by filing your insurance claim and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. The responsibility for payment belongs to the patient.
- We will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of benefits may be advisable if there is a question concerning coverage.
- We will accept assignment of benefits subject to verification of insurance coverage.
- Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment has begun.

We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, our estimation of your co-payment is due at the time of service. If your insurance company has not paid the *full balance* within 90 days, you will have 60 days to pay the balance.

Should your insurance be denied, full payment is expected at the time of service unless prior arrangements have been made through our office manager.

Please remember that you are responsible for timely payment to your account. Should it become necessary to refer your account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection including attorney's fees and court costs.

I understand the above policy and agree to the terms herein.

Signature:_____ Date: ☐☐/☐☐/☐☐

Parent or legal guardian signature if the patient is a minor