Advanced Endodontics

Repairing and restoring function • Preserving and renewing smiles

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Financial Agreement

1. Payment is due at time of service. We accept cash, checks, Visa/Master Card/Discover and Care Credit.
2. All co-payments, deductibles and non-covered services must be paid in full at the time of service. Returned checks will be subject a returned check fee.
3. All co-payments calculated by our office are estimated based on the information given to us at the time of service by your insurance company. At no time can we give exact co-payments until receipt of payment is received from your insurance agency. The only way to get exact co-payment prior to services would be to submit for pre-determination which may take several weeks before it is returned during which time no treatment will be rendered.
4. Our office will submit claims to your insurance company as a courtesy service to you. It is important to know what services your insurance plan covers; we take no responsibility to know what services your insurance plan covers.
5. Services that we render that are not covered by your insurance plan are your responsibility. Please be aware that insurance companies arbitrarily select certain services they will not cover under your benefit plan. We emphasize, then, as your health care providers, that our relationship is with you, not with your insurance company.
6. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered on the date of the visit - regardless of health insurance coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.
7. Accounts over 60 days past due may be referred to a collection agency and such accounts may be reported to a national credit agency. You agree that we may charge you reasonable collection fees and attorney fees if we are forced to refer your past due account to a collection agency and/or attorney.
8. A rebilling charge of $2.00 and finance charge of 1.5% will be added to all unpaid balances after 30 days.
9. No Show Appointments. If an appointment is made and the patient does not phone to cancel 24 hours prior to their appointed time, there will be a $40.00 charge.

I have read, understand and accept the above statements.

My *Estimated* co-payment is: ________________ Total cost of procedure is:______________

Patient signature: X__________________________ Patient Name: ____________________________

If under 18 years old, circle: parent/legal guardian; relationship to patient: ______________________