

Financial Agreement

Thank you for choosing the office of Dr. Arthur F. Eddy for your dental health care needs.

Insurance: Our office accepts most dental insurances. Please call us with your insurance information several days prior to your first visit so we can verify your insurance coverage. Your insurance policy is a contract between you and your insurance company. As a convenience to our patients, we will be happy to process all insurance claims and pretreatment estimates. However, all charges incurred for treatment provided are the sole responsibility of the patient. We can usually estimate the amount of your co-payment at the time of your visit. All insurance deductibles and amounts not covered by your insurance are due on the day of treatment. You will be responsible for the full fee if your dental insurance company does not pay within 60 days after we submit a claim. We accept cash, Discover Card, Master Card and Visa.

Patients with No Insurance: Full payment is due on the day treatment is provided. For your convenience, we accept cash, Discover Card, Master Card and Visa.

Appointments: We see all patients on an appointment basis, and ask that you call and schedule an appointment in advance. We also ask that is you must cancel your appointment that you give us 48 hours notice. We understand that sometimes circumstances arise that prevent patients from keeping appointments. If 48 hours notice is not given a broken appointment fee may be charged. We request this courtesy because it allows us to see our patients promptly. It also helps us to provide more affordable dental care for our patients.

I understand the financial policy outlined above. I understand that the parent guardian bringing a child for dental treatment is responsible for all fees incurred at that visit.

I understand that a finance charge of 18% annual interest rate will be added to any overdue balance. I further understand that the patient or the responsible paying party is liable for any necessary costs of collection resulting from an unpaid balance including but not limited to attorney's fees.

Signature of patient, parent or guardian

Date

Relationship to patient