FINANCIAL POLICY & CONSENT

Late cancellation policy. I understand Eagle Dental reserves a dedicated chair and time slot for my appointment. Missed or cancelled appointments with less than 24-hour notice will incur a $40.00 late cancellation fee.

Treatment fees. I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the service, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on the contract between my insurance company or managed care company and me,my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.

Insurance claims. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any chances thereto.

Assignment of benefits. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and /or managed care company to make payment directly to the dentist for the costs associated therewith.

Delinquent accounts. I acknowledge payment is due within 30 days of service and that a late payment charge of 1% per month will be assessed on any unpaid balance remaining after 30 days. I consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient signature:____Date_________________

Print Name:____

Guardian/Responsible Party,if minor:___________________________________Date_________________

Print Name:____