Patient Financial and Insurance Agreement

Welcome to our office! We're honored that you have chosen us as your dental health care provider.

Quality dental care is a financial investment. If you have dental insurance benefits, we will work with you to help you understand and maximize your coverage. Your contract for insurance benefits exists between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office.

1. We accept payment for services by cash, check, all major credit cards, Care Credit, and Apple Pay.

2. If you have dental insurance, we will file claims for you as a courtesy. **Ultimately, what the insurance does not cover is the responsibility of the patient.**

3. You may receive an estimate of your liability prior to any appointments so you will be financially prepared.

4. **When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated co-payment and deductible be paid at the time of service on the day of your appointment.**

5. After we receive payments from your insurance carrier, we will bill you for any remaining balance. We ask that your balance is paid within 14 days of receipt of your account statement.

6. If you do not have insurance, your insurance pays you, or you are over your yearly insurance limit, we ask that payment be made in full at the time of service on the day of your appointment.

7. Fees quoted will be valid for 90 days.

8. **Interest in the amount of 1.5% will be assessed on any outstanding balance over 60 days from the date of service to cover rebilling charges.**

9. In the event that an account is turned over to a collections agency, all attorney's fees, court fees, processing fees, and/or collections agency's fees will be the responsibility of the patient.

I have read, understand, and agree to abide by Shady Side Family Dental's financial policy. I have been given the opportunity to receive a copy of this document.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Privacy Practices

I have received and/or viewed a copy of this office's **Notice of Privacy Practices**.

_____

Print Patient Name

_____ _____

Patient/Parent/Guardian Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, but acknowledgement could not be obtained because

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented obtaining the acknowledgement

_____ Other (please specify below)

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