

Dustin V. Goodwin, DDS, PC

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FINANCIAL POLICY

We are committed to providing you with the highest quality of dental care. In doing so, we have created a financial policy to reduce our administrative costs and keep our fees as low as possible. By signing below, you agree to the following:

_____ initial **Financial Agreement:** You agree to pay the amount charged for professional treatment and services for yourself and your dependents at the time of treatment, unless other arrangements are made with the financial coordinator. We accept cash, check, MasterCard, and Visa. You understand that if financial arrangements are necessary, they may consist of payments for up to three months with our office. If payment plans with longer terms are needed outside finance companies with their own requirements will be used. Service charges apply for the use of these companies. Please ask the financial coordinator for an application if you wish to use these services. You further agree that if you fail to pay for treatment as agreed, legal action could be taken against you. Should your account be turned over for collection, you agree to pay **all costs** to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

_____ initial **Insurance Agreement:** If you have dental insurance, we will assist you in processing your insurance claims. This is a service that we provide to our patients. In order to process your claims, you must bring proof of insurance to your appointment. ***You, the patient, are responsible for payment of dental care regardless of the status of the claim.*** Your insurance plan is a contract between you and the insurance company. We cannot guarantee the payment of your claim. Reduction, down-grading of procedures, or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

_____ initial **Returned Check Agreement:** You agree to pay a \$20 fee for returned checks.

_____ initial **Broken Appointment Agreement:** In order to adequately treat your dental needs in a timely manner, and to accommodate fairly all patients who require care, keeping your appointment with us is very important. We require 24 hour notice for cancellation or rescheduling of your appointment. ***You understand that you may be charged a \$40 fee for missed or cancelled appointments that occur with less than 24 hour notice.***

I acknowledge that I have read this Financial Policy in its entirety and agree to be bound by all terms and conditions herein.

Patient Name

Responsible Party Name

Responsible Party Signature

Date