Patient Financial Agreement

You (the patient) will be held **responsible for payment on all dental services** that are provided to you by our office. For those who have dental insurance, any payment that your insurance does not cover you will be held responsible for.

Unpaid balance policy: you will be sent up to three notification letters if balance is left unpaid. The first notification is sent to inform you of your balance with us. Second notification is a reminder and warning. Third notification is to inform you that we will be sending your unpaid balance to a collection agency and you will be dismissed from our practice.

Payment plan arrangements: If a payment plan has been arranged by our business office, the payment must be made in a timely fashion as stated in the payment agreement. If the responsible party fails to make their payment after their first notification letter, they will be sent to the collection agency and dismissed from the practice.

If payment is made by check and the check bounces, then the patient will be subjected to a **return check fee of $25.00** in addition to the unpaid balance**.**

No Shows/Cancellation Fee: Our cancellation policy requires you to cancel your appointment during business hours within **24 hours** or a "**No Show" fee of $50.00** will be applied.

____________________________________ ________________
Responsible Party Signature Date