Douglassville Family Dental Associates

Dr. Diedra Alston

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to provide you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up to date information and educational materials and tools so that you mat fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full or with a payment plan.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance company, is due at the time of the treatment. If unable to provide the copayment, there are payment plans available. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts, cash, personal checks, credit (Master Card, Visa, American Express and Discover.) Third party, extended payment financing is available upon request and approval agreement.

Returned check and balances older than 60 days will be subject to collections fees and finances charges.

Additionally, our practice will charge you for an appointment that you do not keep and for appointments that you do not cancel with a 48-hour notice. Emergencies do happen; there are exceptions.

Please do not hesitate to ask if you have any questions or concerns regarding this agreement. We are committed to provide you with the ultimate experience in your dental care.

I have read and accept the terms and conditions of this financial agreement. I authorize my insurance company to pay my dental benefits directly to this practice.

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Print Name of Patient or Responsible Party **Date**

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Signature of Patient or Responsible Party **Date**

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