Family Care Dentistry
Financial Agreement

Thank you for choosing Family Care Dentistry as your Dental home.

Please take a moment to read the following, **sign and date the bottom of this form.**

I understand that and agree to be responsible for payment or co-payments on my behalf or my dependents' behalf on the day service is rendered.

If applicable, Insurance is not a guarantee of payment. We will file dental insurance claims at no cost to you as a courtesy.

I recognize that any and all treatment plans that are presented to me are estimates only. I understand treatment plans can change during care and I could have additional expenses not covered by insurance. I am aware that Family Care Dentistry will provide the best information possible to estimate my cost and insurance coverage. I recognize that Family Care Dentistry has no control over insurance policies or their payments. **Any amount not paid by insurance is my responsibility.**

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge of $35 as this time could be given to another patient in need.

There will be a $35 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 90 or more days will be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost of 33.3%. Further, in the event any unpaid account balance is referred to an attorney for collection, you will be responsible for all court costs and reasonable attorney's fees incurred in connection therewith.

Print Patient name: ____

Signature of Patient or Guardian : ____

Date :__________________________