

**Patient Financial Agreement**

Dear Patient,

Thank you for choosing Green Dental for your dental needs. We are committed to providing you with excellent care. We believe in open and honest discussion of recommended treatment options, respective fees and patients’ financial capabilities.

**Cash Accounts:** As the patient, you are responsible, at the time of service, for all expenses incurred during your office visit. Green Dental accepts cash, checks, MasterCard, Visa, Discover, and American Express. We also accept CareCredit, which is an option for the patient as a payment plan. Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:** Green Dental is committed to helping patients maximize their benefits. All estimated co-pays and non-covered services are due at the time of service. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will submit your claims as a courtesy. **Your insurance policy is a contract between you and the insurance company.** Green Dental participates with many insurance carriers and it is your responsibility to verify if we are a participant in your specific dental plan. You are also responsible for informing Green Dental if your insurance changes. Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minors:** The parent/guardian that accompanies the minor child/children to the appointment is responsible for any payment due. Independent of what a divorce decree or court document says we will not intervene. Reimbursement must be made between the parties involved. We will not bill or try to collect from another party.

 Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Missed Appointments:** Green Dental, as a courtesy, will call to confirm your upcoming appointments. Each appointment is a reserved time made specifically for you. You are ultimately responsible to keep your reserved appointments or call us no less than **24-business hours** in advance to reschedule. Green Dental may charge you a $50.00 missed appointment fee for appointments missed and not changed or cancelled with 24 hours prior to the scheduled appointment. Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Returned Checks, Balances Due and Collection Process:** There is a $25.00 service charge for a returned check. The amount of the returned check along with the fee will need to be paid in cash. Patient balances are due immediately and not contingent upon receiving a statement. If you default and your account is referred to a collection agency or attorney, you will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in the final bill. You also will not be able to schedule any future appointments and will be asked to transfer your records to another dental office. Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Records Release:** Green Dental will only release dental records when a valid HIPAA compliant authorization or a court-ordered subpoena is received. Please allow at least 14 days for your records to be copied and transferred to the requested designation. This does not include the time it takes to be shipped or mailed. Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization of Treatment:** I permit the dental provider and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the dental provider will explain to me the recommended treatment and risks, if any. I have read and agree to the terms outlined in this agreement.

SIGNATURE (patient or guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_

FOR (Print Patient Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_