

Payment Agreement Form

Our Payment and Insurance policies are below. If you have any questions, please do not hesitate to ask.

Initial

We file claims on your behalf to your insurance company and will try to collect payment for 60 days. If insurance does not pay within 60 days, the balance is due from you. After 90 days, your account will be delinquent. In the event insurance pays at a later date, such payments will be for your reimbursement.

All treatment may be postponed for delinquent accounts per the guideless above. Unless other arrangements are made, payment of the *“patient’s estimated portion”* is due in full at the time of service.

Treatment including a lab procedure requires payment of patient’s portion *before* treatment begins.

Insurance payments and benefits are *estimated* as a courtesy for you. **We cannot give exact insurance quotes or guarantee payment before treatment.** Therefore, please be aware that balances can occur after your insurance processes the claim. In such cases, statements for payment from you will be mailed accordingly.

Cancellations within 24 hours or no shows for appointments will be charged \$35.00.

- I authorize payment by my insurance company directly to Arnette Family Dentistry.
- If insurance benefits cannot be verified before treatment, then payment in full is required before treatment.
- All return checks will be subject to a \$35 return check fee.
- Payment plans are offered through Care Credit.
- At the discretion of the office, certain appointments may require prepayment to reserve the appointment.
- Emergency Treatment: If you are not a patient of record, payment is required in full at the time services are rendered. Any dental insurance will be filed for your reimbursement.
- Children: You are responsible to send payment for dependents not accompanied by an adult.

Who Will Be Responsible For Your Account:

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

I have read this form and had an opportunity to ask questions. I agree to the terms of this agreement. No modifications apply to this document.

Signature: _____ Date: _____