

## Financial Agreement

### Payments:

- Payment is due at the time of service
- We accept Cash, Personal Checks, Visa/MasterCard/Discover
- 5% Courtesy Savings for a full Cash/Check payment on the day of service (\$800 or more)
- 3% Courtesy Savings for a full Credit Card payment on the day of service (\$800 or more)  
\* Photo Identification required

### Emergency Dental Services:

- Any/all emergency dental services must be **PAID IN FULL by CASH or CREDIT CARD** the time services are performed.  
\* Photo Identification required

### Insurance:

- Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment.
- Claim amounts not covered by the insurance company are the responsibility of the patient.
- Co-Pay percentage estimates are due at the time of service.
- In order to file insurance claims we require complete employer and insurance information. Inability to file claims due to incomplete information will result in the treatment payment in full at the time of service.
- Insurance claims not settled by your insurance company within 45 days of submission will need to be handled promptly. It is the patients' responsibility to follow up with their insurance carrier to determine the reason for the delay.
- Insurance companies that send payments directly to the patient will be required to pay for the entire treatment at the time of service. Platte Valley Dental Care will file the claim for the patient.

### Service Charges:

- A finance charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of insurance status.
- You are responsible for all fees associated with the collection of debt for professional services provided to this patient by Platte Valley Dental Care including but not limited to collections costs, finance charges, court and attorney fees.

### Minor Patients:

- The adult accompanying a minor on the day of service and the parent(s)/legal guardian(s) are responsible for full payments.

\_\_\_\_\_  
Patient Name (Please Print)

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of payment and agree to their content.

\_\_\_\_\_  
Signature guarantor of payment/responsible party      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_