

LEGACY DENTAL GROUP FINANCIAL POLICY AND AGREEMENT

We realize that every person’s financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile while respecting to your budget. With regards to dental insurance or benefits, we are happy to file the forms necessary to see that you receive the full benefits of your coverage; however **we can make no guarantee of any estimated coverage**. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid the estimated portion within 30 days from the date of treatment, you are responsible for payment at that time. **Please present your insurance card at each visit. To better serve you, all insurance information must be provided at the time of service and before you are seen. Please be sure to notify us of any changes to your insurance, contact information, or residence.**

We understand that occasional scheduling conflicts or emergencies happen. We ask that all patients understand our need to maintain our schedule so that we can provide necessary care to all our patients with a scheduled appointment. For this reason, we require a 24 hour notice for routine appointments and a 24 hour notice for each half hour scheduled with the Dentist or Hygienist to avoid a missed appointment charge for any foreseeable schedule changes which would cause any appointment to be missed, cancelled, or rescheduled. We will attempt to confirm, but ask that all patients be responsible for knowing their scheduled appointment time and date. **Please be aware that we do not honor cancellations via email.** Please be aware that chronic appointment failure may result in dismissal from this practice.

FINANCIAL ARRANGEMENTS: **Cash or Check:** We are happy to offer a pre-payment courtesy for all treatment paid in full prior to the day of your treatment. **Restrictions apply with dental benefit and insurance plans.** **Credit Cards:** For your convenience we have made arrangements to accept payment by MasterCard, VISA, American Express, and Discover. **Payment Plans:** Creditworthy patients who have extended treatment may be eligible for in-office financing. We will work closely with you to customize a plan to suit your needs.

MINOR PATIENTS: **All minor patients must be accompanied by an adult (parent or legal guardian).** The adult accompanying the minor patient is required to pay in accordance with our policies. We can neither accept third party assignments nor do we recognize or enforce the terms of divorce or child support decrees. **All treatment rendered on a minor requires a signature of informed consent by a parent or legal guardian.** Contact our office to make arrangements for any necessary signatures and consent prior to your dependent's appointment if you will be unable to accompany your child or dependent for which you are a legal guardian.

NOTICE OF FEES: Missed appointment fee for a routine appointment \$25.00, for appointments with the hygienist, \$25.00 per half hour scheduled, and for appointments with the Dentist, \$50.00 per half hour scheduled. A non-refundable deposit may be required when scheduling appointment longer than 1 hour.

DELINQUENT ACCOUNTS: Past due accounts will be subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office. In addition to collection fees, all outstanding balances will be subject to an interest rate of 21% APR and reporting to all major credit bureaus.

RECORDS DUPLICATION: (please allow 7-10 business days for processing) \$25.00. Same day records duplication (with minimum 4 hours notice and authorization) \$50.00. There is not a duplication charge for records we process for our referrals to a specialist.

I acknowledge that I have read, understand and agree to abide by the terms of the financial policy of Legacy Dental Group.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

Name of the person signing this form is not the patient: _____

Relationship to the patient: Check one: Parent Legal Guardian