

ARNOLD DENTISTRY, PA
Scott D. Arnold, DMD
Karen L. Morelli, DMD

FINANCIAL AGREEMENT

PATIENT/ACCOUNT NAME: _____

Arnold Dentistry is concerned about your dental health. We look forward to helping you with your dental care. Please remember that Your Dental Insurance Is Ultimately Your Responsibility- but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept Assignment of Benefits from most insurance companies. This will help to reduce your immediate, out-of-pocket expenditures. Any outlined estimate given is based on the limited information obtained from your insurance company and is never a guarantee of payment. When filing claims on your behalf, we allow 30 days for your insurance company to make payment. We make every effort to provide them with all the necessary information to process any and all claims to get your maximum benefit paid. After 30 days, all inquiries (follow ups) on payments due become your responsibility. We may assist you in this process by providing you with the necessary information or documentation to further process the claim.

Once claims are paid or the allotted time for payment has passed, a statement will be mailed to you for the account balance that is due. You will have a 14 day due date from date of mailing to satisfy the balance on the account. If payment has not been received by the due date, the Credit Card or Care Credit account on file will be utilized for payment.

In order for Arnold Dentistry to continue with treatment, we must have your authorization to utilize a Credit Card or Care Credit.

THIS AUTHORIZATION IS USED FOR OVERDUE ACCOUNT BALANCES ONLY! AN ATTEMPT TO NOTIFY YOU OF BALANCE DUE WILL BE MAILED 14 DAYS PRIOR TO ANY CHARGES BEING PROCESSED

- Credit Card on File, Please Circle: VISA M/C DISCOVER BANK ACCOUNT DEBIT

Card Number: _____ Exp Date: _____

- Care Credit: Interest Free Financing (\$300 & up) or Extended Payment Plan (must qualify)

Card Number: _____

******If for any reason this account becomes delinquent, I acknowledge that I will be solely responsible for any and all collection fees, attorney fees and/or court fees.**

******A \$65 CANCELLATION FEE WILL BE CHARGED IF I OR A FAMILY MEMBER ON MY ACCOUNT FAILS TO SHOW FOR AN APPOINTMENT. THIS FEE WILL ALSO APPLY IF AN APPOINTMENT IS NOT RESCHEDULED OR CANCELLED WITH AT LEAST A 48-HOUR NOTICE.**

By signing below, I understand the terms and conditions of the above mentioned Financial Agreement and do hereby authorize ARNOLD DENTISTRY, PA to debit the account named above for any balance due 30 days after the date of service (for any member on the same account.)
PLEASE READ THE ABOVE INFORMATION THOROUGHLY BEFORE SIGNING.

Signed: _____ Witness: _____
Responsible Party/Patient Signature

Date: _____

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