CONTOS SMILE CENTER

# FINANCIAL AGREEMENT

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our Financial Coordinator for an approximate cost **prior** to treatment. We realize that every person's financial situation is different. We offer the following payment options:

1. Cash, Check, Visa, Master Card, Discover
2. Flexible payment plans upon approval with CareCredit and SpringStone. Approval must be received prior to treatment date.

A $35 service charge will be assessed on all returned checks. All emergency dental services or any dental service performed without previous financial arrangements with the office Financial Coordinator must be paid for at the time of service.

Payment is expected when services are rendered. For every treatment appointment, **20% of the patients' portion** will be collected **prior** to reserving an appointment. The remaining balance is due when services/treatments are rendered. Financial responsibility on the part of each patient will be determined before treatment with our Financial Coordinator. Any dental service performed without previous financial arrangement or **verified** dental insurance must be paid for at the time of service.

**Patients covered by insurance**

Our office is considered **out of network** with dental insurances. Some policies do not allow for out of network coverage.

***It is your responsibility to know your policy.*** As a **courtesy** to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. We can generally **estimate** your benefits with reasonable accuracy; however, you will be held **fully** responsible for any amount not paid by insurance regardless of the reason they refuse payment. **Our office recommends and provides dental care to help you achieve optimal dental health and not whether your insurance company covers it.** Please note your insurance policy is an agreement between yourself and the insurance company; therefore, all charges are your responsibility.

Twenty percent (20%) of your estimated portion along with your deductible is due **prior** to your treatment visit and the balance payable in full at the time of your visit. A refund or a credit to your account will be given when the benefits have been received from the insurance company.

- I authorize all benefits be payable to Dr. Aristides Contos, and I agree to release any and all information necessary for the dental office to process claims and release information and payment of my dental benefits directly to this practice.
- I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I authorize the use of my signature on all insurance submissions.
- Additionally, by signing this form I authorize Dr. Aristides Contos to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.
- I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. I grant my permission to you to telephone me at home or work to discuss matters related to this form.
- I have read and understand the above financial and office policy agreement and have had an opportunity to have my questions answered. I understand that by signing this document, I agree to all the terms contained within it.

**Print Patient Name:** _____

**Signature of Patient and/or Legal Guardian:** _____ **Date:** _____/_____/_____

**Relationship to Patient:** _____

## Appointment Policy

***Our time is valuable and so is yours.*** Please understand that we reserve chair time just for you when you make an appointment. In an effort to continually provide quality service please keep your reserved time as scheduled. **Our office needs 24 business hours notice if you need to change/cancel your reservation.** If such notice is not received, there is a **$50.00 broken reservation fee**. A broken reservation is one that is no showed or cancelled/rescheduled without 24 hours notice. Please remember scheduled appointments are time reserved specifically for you with our Doctors. Your 24-hour notice allows us to offer your time to other patients awaiting dental treatment they deserve. After 2 consecutive broken appointments, our office will require a 20% non refundable prepayment for future reservations, in addition to your financial responsibilities outlines above.

In order for our office to properly manage your dental care needs current information is imperative. Please keep your records up to date by informing us of any changes to your account. This would include but not be limited to: name, address, phone numbers, email address, employer, insurance and all medical/health history.

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT AND APPOINTMENT POLICY.**

**Signature of Patient and/or Legal Guardian:** _____ **Date:** _____/_____/_____

*Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please let us know.*