Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I have dental insurance, I authorize and request my insurance company to pay directly to my dentist.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.
Payment options: Cash, Check**,** Master Card, Visa, Discover, AMEX, CARE CREDIT Financing Plan

Patients with insurance: The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card after insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. Please understand that this is only an insurance estimate and is based upon the information available to us. Once your insurance carrier has paid the claim, any difference will be due upon receipt of our statement. If you insurance company postpones payment for more than 90 days, we ask that you make the remaining payment while we work together to get the insurance company to pay you their obligations

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).
Parents accompanying their children are financially responsible for payment.

18% annual interest is charged for any unpaid balance. There is a $30.00 processing charge for non-sufficient funds or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, ____ , agree and authorize to these financial terms.
Signature ____ Date___________

PRIMARY DENTAL INSURANCE INFORMATION ●NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME MIDDLE		FIRST	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATI SUBSCRIBER ●SELF ●SPOUSE ●CHI ●OTHER	

SECONDARY DENTAL INSURANCE ●NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME MIDDLE		FIRST	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATI SUBSCRIBER ●SELF ●SPOUSE ●CHI	

Smile Art Dentistry

CONSENT FOR TREATMENT

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized.

Signature of patient or legal guardian

____Date________

MISSED OR BROKEN APPOINTMENTS

We appreciate you and your family coming to our office. We strive very hard to give you the best dental treatment available.
To ensure that each patient receives adequate treatment, it is important that our office has current phone numbers and addresses at all times. It is necessary that we confirm all appointments. Our office calls 1 to 2 days prior. In the event that we cannot contact you due to invalid phone numbers, we reserve the right to cancel your appointment.
If you need to reschedule or cancel an appointment, please give our office 2 business days notice, on all cleanings and dental treatment appointments. We require a 3 day cancellation notice for all sedation appointments. You may leave a message on our answering service, (858) 566-2151 24 hrs. a day.
If you miss an appointment without notifying our office, we reserve the right to charge a missed appointment fee of $50.00.

I acknowledge the terms and conditions above.

____ ________________

Patient Signature Date