FINANCIAL AGREEMENT

Thank you for choosing our practice to care for your dental needs. We are committed to your treatment being a successful and positive experience. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to seeing the doctor.

Regarding Insurance
Please be advised that different insurance companies and policies may offer different fee schedules and to whom they make payment. If we know in advance that a particular company, group, or policy will not pay for a certain procedure or will not pay our office, then we will require payment be made in full at the time of service. Please understand that different policies\group for the same company may have different benefits. With certain insurance companies the insured instead of the provider is paid, in these cases, full payment will be expected at the time of service. However, we will file the insurance for you anyway. Also, we will estimate what we feel your portion of the treatment will be, and let you know what the estimate is. Again, this is only an estimate. However, it is not our responsibility to know your exclusions, waiting periods, and non-covered procedures in your insurance policy.____ (initial)

Usual and Customary Rates\Fees
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. ____(initial)

Patients Without Insurance
Payment is due in full at the time of services are rendered. We do offer a payment plan provided by an outside financial institution. After a brief credit check, they will extend credit accordingly _____(initial)

Patients with Insurance
As a courtesy, we will file your insurance claim. We will file it once and if after 30 days, your insurance has not paid the claim, we will resubmit. If we have made an error, we will correct the error and refile the claim. However, please note that it is the policy of Green Oaks Dental/John J. Crumpton, DMD, PC to be paid upon services rendered. The patient and/or guarantor is ultimately responsible for any balances due to this office. After 30 days, the patient/guarantor is responsible for the bill while any outstanding insurance issues are being handled by this office or the patient.

Minor Patients
The parents or legal guardian of a minor is responsible for full payment. Treatment will be denied unless a parent or legal guardian is with the minor._____ (initial)

Financial Charges that may apply

Even if an insurance claim is outstanding, your statement will show the total amount owed on your account. Unpaid amounts of at least your estimate portion should be paid prior to leaving our office. If other arrangements have been made prior to leaving our office, then this amount is due within 10 days of your receiving a statement from our office. Finance charges of 1.5% will be computed on all balances shown to be older than sixty (60) days. This applies to accounts that have a payment agreement. We believe this is a fair policy, as it allows a generous grace period, free of any finance charges. The minimum finance charge to be applied to an account is $1.50. Accounts with a balance older than 90 days, toward which there has been no or insufficient payment, will be considered delinquent and may be subject to collection by means of a collection agency, civil suit, or both. In such cases, the patient debtor shall bear ALL collection costs, including but not limited to, attorney fees and court costs. Finance charges of 18% APR will apply to collection cost and court costs from the date they are incurred and posted to the patient's account. Finance charges will continue to accrue until the entire balance of all charges, including finance and collection charges, is paid in full. Additional, the grace period will not apply or be recognized and finance charges will be computed from the date of treatment. Other fees may apply. __ (initial)

Broken Appointments

If you find you must change your appointment, we require a minimum of a 24 hour notice so that we may accommodate another patient. Please do not wait till the day of appointment unless it is a true emergency. A charge of $50.00 maybe applied for missed appointments without notice and late appointment cancelations (less than 24 hours). Thank you for your cooperation in this matter.

There will be a $35.00 charge on ALL returned checks.

By signing, I do hereby understand and agree to the terms listed above. I accept FULL financial responsibility for ALL charges and understand I am released from this responsibility ONLY when the account is paid in full, whether by the insurance company or me. I understand that payment is due when treatment is rendered. I authorize Dr. Crumpton and all the dental staff of Green Oaks Dental! John. J. Crumpton, DMD, PC to perform all necessary dental services on myself including but not limited to x-rays. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy.

_____ Signature of responsible party

_____Date