FINANCIAL POLICY

*****YOU ARE FULLY RESPONSIBLE FOR YOUR ACCOUNT*****

1.
Dental Insurance: We are happy to file the necessary forms to your insurance company so that you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and the insurance company, you are ultimately responsible for all charges. Estimated patient payments must be paid at the time of your appointment.
(___)

2.
Any accounts not paid in full within 90 days will be placed with a collection agency and listed with the credit bureau. You agree to pay all collection and attorney fees if suit were instituted to collect money owed by you. This includes fees of up to 40% of the unpaid balance that may be assessed by our dental office to pursue this matter.
(___)

3.
You grant permission to our office to telephone you at home or at your workplace to discuss matters related to your account.
(___)

4.
You authorize assignment of payment of all dental and/or surgical benefits to which you and other family members are entitled to Dr. Joe Pinney. This includes private dental insurance and other group health plan benefits otherwise payable to undersigned.
(___)
5.
I understand that there will be a $25.oo charge on all returned checks. I understand that after one returned check the only acceptable payment method will be cash.
(___)
6.
Patient will be responsible for missed appointment fee of $25.00 if not cancelled 24 hours prior to appointment.
(___)

I certify that I have read this form and that I hereby agree to abide by the conditions outlined herein**.**

_____ Date_____ _____
Responsible Party's Signature Relationship to Patient