FINANCIAL AGREEMENT

Logan Peak Dental

PAYMENT IS DUE AT TIME OF SERVICE

All financial arrangements are to be made before any treatment provided. Patient responsibility is collected on day of treatment.

PAYMENT

We accept cash, check, debit/credit cards (Visa, MasterCard, Discover, American Express). We also accept CareCredit (a healthcare credit card). CareCredit, no-interest plans are not offered to patients that have dental insurance. Prior to appointments, if needed, arrangements with your choice of patient financing is required. All patient financial responsibility is due at dental appointment. Only cash or credit cards will be accepted for emergency treatment.

FINANCE CHARGES

2.33% per month (annual percentage rate of 28%) of the unpaid balance will be added monthly. In addition, a monthly service billing charge of $2.50 will be charged on the account. If any payment is late, a $10 monthly service charge will be charged monthly until account is paid off. Account balance that is 60 days past due will become due and charged 40% of the current balance and turned over to our collection firm. Any further payments will be paid to them.

RETURNED CHECK CHARGES

$25 plus any bank charges we may incur will be charged to the account. Patient will have 3 days to bring cash to the office to replace returned check and bank charges. After 3 days, your account will be charged additional collection fees (40% of your current balance) and will immediately be turned over to our collection firm. Any further payments will be paid to them.

BROKEN/MISSED APPOINTMENTS

A $50 charge will incur for any appointment that is cancelled or rescheduled within 48 hours of the appointment. All missed appointments will be charged the $50 fee. Payment of this fee will be collected before any further treatment is started.

COLLECTIONS

Should collections become necessary, the responsible party of the account agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

LAB CASES

LAB CASES: Procedures and cases that require services from an outside lab for crowns, bridges, night guards, retainers, etc, 50% will be due when impressions are taken and the remaining 50% will be due when received.

INSURANCE

Insurance claims will be filed as a courtesy to you. Your insurance is a benefit and contract between your Employer or insurer, and you. Our total fees for completed treatment are due within 60 days of the date of treatment, regardless if insurance has paid.

We make every effort to verify and help to get claims paid. We are not responsible for denied claims. Insurance companies are changing the fine print of their policies. All insurance quotes given are estimates of your benefits. Co-pays are due on date of service and are an estimate of your patient responsibility. We strive to provide you with the most accurate insurance and co-pay information available to us at time of quote. Benefits quoted are subject to your available benefits on the date insurance claim is received. This may include, but not limited to, a deductible, downgrading on posterior composites and crowns, bundling, or excluded services by your insurance policy. You are responsible for knowing what benefits you have with your insurance and also making sure we have the current insurance information for your account.

Please call your insurance company to verify your benefits if you have any questions.

FAMILY ACCOUNTS

All patients 18 and older must fill out and sign a Financial Agreement. The guarantor of the family account must sign a Financial Agreement. Anyone 18 and older will ultimately be personally responsible for themselves.

DIVORCED PARENTS

Co-pays for any services for dependents are due on date of service. Treatment plans are provided prior to appointments with estimated co-pays. If needed, a prior arrangement with a parent needs to be taken care of before the child's appointment. Copays need to be paid in full at or before the child's appointment.

☑ This Financial Agreement will apply to all family members unless specified otherwise.

☑ I grant my permission to you, or your assignee, to telephone me to discuss matters related to this form.

☑ I have read the above conditions of treatment and payment, and agree to their content.

Signature of Guarantor/Responsible Party : _____ Date: _____

Print Name: _____ Family Relationship: ☐ Parent ☐ Spouse ☐ Child

LOGAN PEAK DENTAL

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