# **Austin R. Smith DDS**

# **Dental Office Financial Agreement**

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. 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 that you read and sign prior to any treatment.

***GENERAL:***

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.

***MISSED APPOINTMENTS:***

Unless we receive notice of cancellation **48 hours in advance** you will be charged **$100.00**. Please help us service you better by keeping your scheduled appointments.

***INSURANCE:***

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. While we try our best to have complete and accurate information on insurance plans, it is physically impossible for us to have knowledge and keep track of every aspect of your specific insurance plan. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to your treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether your insurance company pays any portion.

***PAYMENT:***

**FULL PAYMENT** is due at time of service. If insurance benefits apply, ***ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at time of service***, unless other arrangements are made.

**Unpaid balance over 60 days old will be subject to monthly interest of 1/5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney’s fees, and court costs associated with the recovery of the monies due on the account.**

The parties agree that in the event of a dispute over any payment or fee due to Dr. Smith by the undersigned, the District Court of Thurston County shall have exclusive jurisdiction and venue for any litigation filed by either party.

**By Signing this Financial Agreement, I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentist to release any information required to complete my dental claims. I authorize that my records can be used by the Dr. if he so determines.**

**I authorize the Dr. and his auxiliaries to take any diagnostic aids deemed appropriate by the Dr. to make a thorough diagnosis and completely treat my dental needs.**

**I have read, understand, and agree to the terms and conditions of this Financial Agreement.**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**