

Jackson Creek Dental

Financial Agreement Form

Thank you for choosing our dental practice. Dental treatment is an excellent investment in an individual's overall well being. We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time.

Payment is expected at the time service is rendered unless other arrangements have been made prior to treatment.

Payments can be made by cash, check, or credit card. We offer a credit card payment plan for a maximum of three months. We also offer **Care Credit Financing** for qualified applicants with up to 12 months free financing. An application may be filled out in the office or you can apply online at www.carecredit.com.

Insurance – For our patients with dental insurance, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we cannot make a guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy. If the patient's insurance fails to make full payment after 60 days, the patient is responsible to pay the outstanding balance on the account.

Flex Plan/Spending Accounts – Payment in full is expected at the time your service is rendered. We will be happy to give you a copy of your receipt which will allow you to submit the amount to your Flex Plan/Spending account for reimbursement directly to you.

Short Notice Cancellations – If there has not been a reasonable amount of time given prior to your cancellation, a fee may be charged to your account. We reserve the right to charge and collect fees for appointments that are cancelled or broken without 24 hours advance notice. Appointments are reserved specifically for you. If cancelled or failed, the time is taken away from other patients who are waiting to be placed in our schedule. A fee of \$20.00 for the first and \$30.00 for the second failed appointment will be charged to your account.

Returned Check Fee - \$30.00 will be added to your account balance if a check is returned to us as Non Sufficient Funds.

I accept full responsibility for all treatment performed by Drs. Tschetter and Howder. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement between myself and my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including, but not limited to, attorney's fees and court costs.

Signature of Patient, Parent or Guardian, or Responsible Party

Date

Witness

Date