Financial Agreement

Thank you for choosing Green Valley Dental for your dental care! In order to provide better service of our patients and minimize costs, financial arrangements will be made in advance of treatment. Payments for services are due when services are rendered. **We will try to give you the most accurate estimate possible from the information given to us from your insurance company.** We accept cash, checks and major credit cards.

As a courtesy to our patients with dental insurance, we will be happy to file the claim for you, **but you are ultimately responsible for all costs of treatment incurred.** Please understand your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract. **Not all of our services are covered benefits within insurance companies.** The patient must have current and updated information at all times in order to bill insurance accurately. **It is your responsibility as the policy holder to inform the office of any changes in your information.** We will try to contact your insurance company to verify coverage and check your co-pay and deductible amounts. You will be responsible for any co-pays, or deductible amounts at each visit. If your insurance does not pay in full within 30 days, we ask that you contact your insurance company directly.

Accounts over 60 days past due will be assessed a finance charge of 1.4% monthly; annual percentages of 16.8%. After 90 days, patients not responding to statements and/or contacts of overdue accounts will be sent to collections.

There will be fees assessed for all missed appointments. The fees are as follows: $100-per hour of doctor time scheduled and $72-per hygiene visit. These fees can be avoided by providing our office notification 24 hours in advance of the appointment previously scheduled. **If we do not reach you from the confirmation call, it does not excuse your responsibility from keeping your appointment.** That call is merely a courtesy we provide to our patients.

I understand that I am ultimately responsible to pay for all services rendered and in the case of default, the cost of attorney's fees, court costs and the cost of collection proceedings. I have read the above conditions of treatment and payment and agree to their content.

x

Signature of patient, parent or guardian **Date**