FINANCIAL AGREEMENT/CANCELLATION POLICY

Insurance: Please know and understand that your dental insurance is a contract between you and your dental insurance company. We file insurance as a courtesy to our patients. It is your responsibility to know and understand your dental insurance coverage in regards to maximums, frequencies and procedures covered and non-covered services.

I hereby authorize any insurance benefits to be paid directly to Harris Family Dentistry P.C. and recognize my responsibility to pay for all non-covered services and my estimated patient portion at the time of service. I also authorize the release of any information necessary to process an insurance claim.

I acknowledge that all non-current balances on accounts over sixty days could accrue a service charge of 1.5% per month on the unpaid balance. Any additional costs incurred in collecting on this account will be added to your balance due and will be your responsibility. A statement re-billing fee of $15.00 per month will be added to all accounts with patient balances over 60 days. Also, if the account is turned over to our collection agency because of non-payment the collection agency adds a 40% collection fee to the unpaid balance. This is in accordance with our financial policy.

I further understand that treatment recommendation may change due to severity or time elapsed between diagnosis and treatment. Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the dentist. I understand I have the right to see a dentist, if I choose, and have the right to see the dentist prior to any prescription drug or service order being carried out by a dental assistant.

I, the undersigned (patient and legally responsible party) authorize treatment to be rendered and assume financial responsibility. Charges for all minors are the reasonability of the parent, guardian, or individual presenting the child for treatment. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

FORMS OF PAYMENT:

Cash Check Visa/MasterCard/American Express

CareCredit – *offers a line of credit with no interest for promotional periods if applicant is approved. Please ask receptionist for brochure explaining the CareCredit options. To apply call 800-365-8295 or www.carecredit.com and click on "Apply".*

BROKEN AND LATE NOTICE CANCELLATION POLICY

Our office offers multiple courtesy reminders: appointment cards, phone calls, postcards through the mail, reminder email and texts to your cell number. If you are not receiving these electronic reminders and would like to do so, please contact our office to set up your contact information. We call to confirm as a courtesy, but it is the responsibility of the patient to respond to the confirmation calls/texts/emails and present for their appointment.

A broken or late cancellation affects other patients who are awaiting an appointment for needed treatment. Should you expect a schedule change please allow at minimum, a 48 business hour notification to reschedule your appointment. Without proper notice we are unable to offer the time to other patients who may be needing immediate care and would charge a cancelled appointment fee of $50.00 to your account. Your cooperation with this matter is appreciated.

I have read the above Financial Agreement/Cancellation Policy and have asked any questions regarding the policy. By signing below, I understand and agree with the terms of this policy.

Signature of patient or responsible party Date

Office hours: Mon, Tue, Thu 8 am – 5 pm Wed 8 am – 4 pm