FINANCIAL AGREEMENT
Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING
You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make *estimates* regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS
I/we hereby assign directly to Pleasant Dentistry insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

_____ _____
Responsible Party Signature Date

DELINQUENT ACCOUNTS
All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS
In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any and all reasonable collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS
Failed appointments (less than 24 hours notice) are a significant contributor to rising heath care costs. **Individuals who fail to show for a confirmed appointment will be assessed a fee based on the length of the missed appointment.**

_____ _____
Responsible Party Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's ***Notice of Privacy Practices***. I understand that I have a right to refuse to sign this acknowledgment.

_____ _____
Responsible Party Signature Date

FOR MEDICARE ELIGIBLE PATIENTS ONLY

I understand that this office is a **non-participating office** with Medicare. I further understand that as a non-participating provider, Pleasant Dentistry will not submit insurance claims to Medicare on my behalf.
I understand that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to services provided by Pleasant Dentistry.

_____ _____
Responsible Party Signature Date

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