FINANCIAL AGREEMENT

Thank you for choosing First Dental for all your dental needs. Although we do accept insurance as a courtesy to our patients, you must understand the following:

- First Dental must have adequate time before your appointment to contact your insurance company to verify coverage.
- A $50.00 no-show - last minute cancellation fee will be charged in the event you do not provide 24 hours' notice or fail to show for your scheduled appointment. This policy is our attempt to ensure that our patients receive the dental care that's needed. We understand emergencies happen and we appreciate your understanding and your communication.
- First Dental does not participate in any preferred provider plans. If your insurance has a network of providers, First Dental will be considered out-of-network. It is your responsibility to be informed about such matters regarding your own insurance. Please call your insurance for related questions.
- Dental insurance usually pays a percentage up to a set dollar amount.
- Most Dental companies will not tell us the exact dollar amount they will pay. So First Dental must estimate your portions.
- The patient or guardian is ultimately responsible for the full amount of payment for services. This means that is the insurance company rejects or underpays a claim for any reason, the patient or guardian must pay in full for the claim or procedure unpaid or underpaid by insurance.
- If the Explanation of Benefits from your insurance indicates that you overpaid for your visit, any previous credit adjustments made to your account or to your dependent family members account will be removed. After all credit adjustments have been offset you may or may not have a true credit on your account.
- First Dental does not accept secondary insurance.
- If your insurance company mistakenly mails the payment to you, you must bring the check to First Dental because the payment rightfully belongs to us.
- If you do not have dental insurance all charges will be due in full at the time of service rendered.

I understand and agree to the above statement, I accept full responsibility for payment of my

(or my dependent's) account balance.

Patient or Guardian Signature: _____

I hereby authorize payment of the dental insurance benefits to be made directly to Alan Imrek, D.D.S. If the insurance company mistakenly mails the payment to me, I will immediately forward and sign the payment over to Alan Imrek, D.D.S.

Patient or Guardian Signature: _____

I authorize release of any information relating to my insurance claim.

Patient or Guardian Signature: _____