Hope
DENTAL PROFESSIONALS
Cosmetic & Family Dentistry

Financial Agreement

As validated by my signature on the bottom of this form, I understand and agree that:

1. All patient balances are due immediately after treatment is rendered.
2. Should a balance accrue on the account a statement will be sent and payment is to be made, in full, within **30 days** of the date on the statement.
    a. If payment is not paid within 30 days interest will be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.
    b. Should this debt go beyond 90 days it will be sent to collections and any additional fees for the collection process will be added to the balance.
3. If a check is returned, a returned check fee will be applied and must be paid immediately from the patient for each check payment returned to us by your bank.
4. Dental insurance is a contract between the patient and the insurance provider. Running, submitting and following up on claims for payment from the insurance provider is a **courtesy provided by the Hope Dental Professionals**, not an obligation. Ultimately, the patient is responsible for any treatment that is unpaid by the insurance provider that remains outstanding 60 days past treatment. As such, until payment is received from my insurance provider, no patient payment is final.
5. Estimates are predictions based on information from and history with the insurance companies. Therefore, estimates are not a guarantee of insurance payments. Estimated fees are good for 90 days from presentation.
6. Estimates do not take into consideration any money that was billed toward the patient's financial maximum or treatment limits that may have been used at other dental/specialist clinics.
7. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Hope Dental Professionals will make an effort to anticipate any changes in the treatment plan and advise the patient at that time. However, such events are unpredictable.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

_____ _____ _____

Printed Name Signature Date