Financial Responsibility Agreement and Consent for Services

Thank you for choosing our team of dental professionals to serve your dental needs. We appreciate the confidence you have placed in us. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following financial policy:

Insurance:
Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

1. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. **Please note that insurance estimates and pre-estimates are <u>not a guarantee</u>** from your insurance company.
3. Your insurance policy is a contract between you and your insurance company; we are not party to that agreement. Some or all of the services we provide may not be a covered benefit. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. It is your responsibility to provide Leesburg Dental with current insurance information.
5. In the event that you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Leesburg Dental, P.C.

Payment Policies:

As a condition of your treatment by this office, financial arrangements must be made in advance. We will discuss financial options with you before rendering treatment.

By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement and Consent for Services including the following:

1. If you have dental insurance, your estimated portion of **<u>payment is due in full at your time of service,</u>** unless prior written financial arrangements have been made.
2. If you do not have dental insurance, **<u>payment for services is due in full at your time of service.</u>**
3. There is a $35.00 service charge on all returned checks.
4. I understand and agree that any account balance not paid within **90 days** will be subject to collection activity. I understand Leesburg Dental, P.C. will retain the services of any attorney to assist with the collection of any outstanding balance.
5. I understand and agree that if my account is turned over to collections I may owe additional fees.
6. I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Leesburg Dental.
7. **Minor patients**: The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.

Print Patient Name: _____Signature: _____

Parent or Guardian Signature: _____Date: _____