NEW HAVEN DENTAL

FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to serving you with the highest quality of care possible. Please understand that payment is considered a portion of the care provided.

- If you have dental insurance, we will file claims as a courtesy for our patients. We do not have a contract with your insurance company, only you do. Most plans pay between 30% to 50% of the average dental treatment fee. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. **You will be responsible for your estimated fees and deductible at the time of service as well as any balance that may remain after your insurance payments are received.**
- If your insurance company has not paid your account within 90 days, you are responsible for the balance of your account.
- Full payments/co-payments are due **at the time of service**.
- We accept cash, check, debit card, Visa, MasterCard, and Discover.
- In addition, we offer easy, affordable payment plans through Care Credit and Wells Fargo. These companies offer patient payment programs with a full range of 0% interest and extended payment plans.
- Checks that have been returned to our office from your financial institution are subject to a $35.00 fee. This will cover the processing fees charged to our office.
- If your account is referred to a collection agency, you will be responsible for all fees occurred.

Missed appointments: If you find you must reschedule or miss your appointment, we require a minimum of 24-hour notice. If proper notice is not given, a charge of $25 will be charged. After two missed appointments or cancellations, you will be required to pay 50% towards next treatment prior to future appointments being made.

Please feel free to ask any questions you may have regarding our insurance or payment policies. We are happy to help you in any way we can regarding the processing of your insurance claims.

By signing below, I understand and agree to the terms and conditions of the New Haven Dental Financial Agreement.

Print Name:_____

Patient Signature:_____ Date:_____

02/01/2019