# FINANCIAL POLICY

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

**Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient. With that said, patient(s) are personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patient's insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed upon by your employer and the insurance company. If you have any questions about the benefits of the plan or the treatment(s) your plan will cover, please refer these questions to your employer's Benefits Administrator.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan, but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.**

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee ESTIMATE(S) listed for any proposed dental care can only be extended for a period of 6 months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment has begun, due to unforeseen circumstances beyond the doctor's control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Stonehenge Family and Cosmetic Dentistry and/or Stonehenge Family and Cosmetic Dentistry's financial coordinator(s) to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of payment for treatment and agree to the terms.

| ______________________________ | ____________ | ________________ |
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| **Signature of patient, parent or guardian** | **Date** | **Relationship to patient** |
| ______________________________ | ____________ | ________________ |
| **Signature of Guarantor of Payment/Responsible Party** | **Date** | **Relationship to patient** |