Patient Financial Responsibility Agreement

OUR FINANCIAL POLICY: Many patients have a commonly held misconception that dental benefit policies their employers, or they individually have purchased, will pay for all their treatment. This incorrect and untrue. If you have a third party payer or pay out of pocket for your dental treatment; **we expect payment at the time of service**. If you have dental insurance we will give you an **estimate** based on the information we receive from your insurance company. We will be happy to assist you with financial arrangements if necessary, such as Care Credit, to help you afford the treatment you require to maintain a healthy, beautiful smile.

DENTAL TREATMENT: As a patient in our office, you will receive treatment that is specific to the conditions diagnosed during your initial and period examinations. The doctor will carefully review these findings with you. We will provide the cost of your treatment to you and will be happy to assist you in obtaining reimbursement for benefits from your third party payer. In return, your financial responsibility for this treatment will be to the doctor's office. Please understand that third party payment is no longer termed "insurance" as it does not guarantee payment even though you may think you have coverage. **Financial responsibilities for you services are ultimately yours and yours alone.**

THIRD PARTY PAYMENT: Usually third party payers will send benefit reimbursement directly to the doctor's office. Typically, your benefits contract has an "allowable benefit amount" for each procedure provided. This amount is determined by the contract that your employer or individual has purchased from the company and may not equal the submitted fee from the doctor. The third party payer will pay a percentage of their "allowable" amount with a co-payment portion assigned to the patient. **You are responsible for any co-payment portions, deductibles, or remaining portion of the cost that is not covered by your third party payer.**

BROKEN APPOINTMENT POLICY: We require a 48 hour notice for canceling or rescheduling appointments. This time is reserved especially for you and we take this commitment seriously. **There will be a $100.00 charge for all broken(no-show) or last minute appointments not cancelled with 24 hours.**

Please be assured, our goal is to make your visit a pleasurable one from the time you meet our caring staff to the completion of your treatment designed specifically to meet your needs. Thank you for your confidence in our office. We look forward to providing you with the highest quality dental care and courteous service.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO **KATHLEEN P.VANI, D.D.S., PLLC**, FOR ALL TREATMENT AND SERVICES PROVIDED TO ME.

Patient Name:_____

Signature:_____

Date:_____