FINANCIAL AGREEMENT

By signing below you acknowledge and understand that payment in full for all services is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING

By signing below you acknowledge and understand that you (patient) are ultimately responsible for payment in full on your account, not the insurance company. We do file dental insurance claims as a courtesy to our patients. You understand that we can only make *estimates* regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, you understand that the remaining balance is due and payable immediately by you.

ASSIGNMENT OF INSURANCE BENEFITS

By signing below you hereby assign all insurance benefits directly to our office which are otherwise payable to you. You also hereby authorize the release of any information relating to any claims. You understand that you are financially responsible for charges not paid by this assignment.

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Responsible Party Signature

DELINQUENT ACCOUNTS

By signing below you acknowledge and understand that all delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS

By signing below you acknowledge and understand that in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any and all reasonable collection costs and/or attorney fees, in addition to the balance owed. All accounts turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS

Failed appointments are a significant contributor to rising heath care costs. By signing below you acknowledge and understand that your account will be assessed a usual and customary fee for any missed or changed appointment with less than a 24 hour notice.

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Responsible Party Signature

PATIENT INFORMATION PRIVACY

By signing below you acknowledge that you were provided a copy of this office's ***Notice of Privacy Practices***, and you also understand that you have a right to refuse to sign this acknowledgment. Additionally, as a recommended office of BestDentalCareAZ.com, we agree to periodic and random quality control assessments to ensure that we continue to meet their high expectations in patient care. Occasionally this includes speaking with an actual patient. By signing below you are providing our office your consent to give BestDentalCareAz.com your limited contact information (phone and email only) as part of their quality control procedures.

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Responsible Party Signature

FOR MEDICARE ELIGIBLE PATIENTS ONLY

By signing below you acknowledge and understand that this office is a **non-participating office** with Medicare. You further understand that as a non-participating provider, this office will not submit insurance claims to Medicare on your behalf. You understand that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to services provided in this office.

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Responsible Party Signature