

We Care Family Dentistry Financial Agreement

Terms of Payment

We are committed to working with you to match a payment plan to meet your needs. We therefore offer different options to our patients which allows for payment to be convenient and flexible. Regardless of your method of payment, the decision must be made prior to your first day of service and your agreed upon portion paid at the first day of your service.

Dental Insurance

To help us assist you in determining your maximum benefit, please bring your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore, as a courtesy to our patients, we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Payment Options

- We accept Visa, MasterCard, Discover, money order, cash or personal check
- A convenient interest free payment plan through Care Credit
- A 3 installment payment plan on your credit card for procedures over \$300; first installment on the first date of service

Appointments

In order to allow the best possible care for our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However if you need to change your appointment due to an emergency, a 24-hour notice is expected.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company, therefore, I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Walter Fingar.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

Signature of Responsible Party

Date