CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

This policy is an effort to avoid any misunderstanding which may arise regarding your account with this office and/or your insurance company. We will try in every way we can to make the billing process with our office and/or your insurance company as simple as possible. If you have insurance, please remember it is your responsibility to know your insurance benefits and limitations.

By signing below, I agree to the following:

1. I am responsible for cost incurred in my or my dependent's care. I understand that charges for services provided are due at the time of each visit. If I cannot pay my bill in full, financing arrangements may be available if I contact the office manager of Rogers Center For Dentistry (RCFD).

2. If dental claims are submitted to an insurance company by RCFD on my or my dependent's behalf, I understand that the co-payment is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to RCFD (assignment of benefits.) I understand and agree that I am financially responsible for all deductible and co-insurance amounts as well as any non-covered service amounts deemed as "unnecessary" or "cosmetic" by my third party insurance carriers. I agree that I am responsible for satisfying any conditions necessary for insurance or dental benefits.

3. Where insurance benefits apply, RCFD will provide me with an estimate of my patient portion. The patient portion is expected in advance or on the day of service. Because RCFD cannot guarantee the amount of coverage the insurance provides, any difference from the estimate will be paid immediately following the insurance payment. If the insurance company pays more than estimated, RCFD will credit my account for future services or write me a reimbursement check.

4. If any unpaid balance is referred to a collections agency, I agree to pay the remaining balance plus all collection costs and fees, including legal fees.

5. I agree that I am responsible for any and all bank charges on returned checks. Additionally, returned checks may be forwarded to a collection agency for immediate collection.

Signature of Patient/Responsible Party: _____Date: _____