HOWARD Family Dental®

Patient Financial Agreement

Patient Name _____ Date _____

Thank you for allowing us the opportunity to care for your dental needs. We are excited to partner with you to improve and maintain your oral health.

For your convenience you can pay for your treatment with cash, check, credit card, or through a third party financing who partners with us, to ensure all patients receive the care they need. We will collect the payment of your treatment at the time of service.

If you would like to use your dental insurance, we will gladly file the insurance claims on your behalf for the portion you expect your insurance to pay. We will also post to your account any insurance payment and adjustments we may receive. We will let you know if your insurance covers only part of the claim, that you may send us the payment for the balance.

If you have the need to change any financial arrangements for any reason, please let us know that we may work with you. In the event, any portion of balance remains unpaid longer than 30 days we will initiate a collection process, which may include collection and financing fees.

Agreement:
By signing below, I confirm that I understand this financial process, and agree with every step. I also state that I am responsible for the cost of my treatment and any third party financing or insurance carrier unpaid balance. I understand and agree that this dental office shares my personal health information for collection purposes only. This agreement does not authorize the dental office to share my information for any other purpose. I understand the dental office may initiate a collection process if any cost for my treatment remains unpaid longer than 30 days.

Patient, Parent (or Guardian) signature: _____Date: _____