fusion
Children's Dentistry & Orthodontics

manager@fusiondentalclinic.com
www.FusionDentalClinic.com

FINANCIAL AGREEMENT

This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our experienced office staff.

DENTAL INSURANCE PATIENTS:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Care Credit, and major credit cards.
- If your insurance has not paid or denied your claim within 45 days, it will be your responsibility to pay the full balance of all unpaid claims.

RETURNED CHECKS: A $50.00 charge applies when the bank returns a check.

THIRD PARTY FINANCING: If a third party is used to finance dental treatment (e.g. Care Credit, Citi Health), you have 15 calendar days to cancel your treatment and receive a full refund. Cancellation requests received after 15 calendar days are subject to a 15% fee on the amount financed.

Cancellation requests received after treatment has begun will be refunded in full minus the fee/price of the services rendered, provided they are within 15 calendar days.

Cancellation requests received after 15 calendar days and after treatment has begun will be processed in the amount financed minus 15% penalty fee, minus the fee/price of the services rendered.

Initials _____

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PAST DUE BALANCE: An account with an unpaid balance past 60 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt from the last date of service, such as attorney fees, court fees and any other fees associated with the collection of your debt.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 60 days of the billing date. A late charge of 1.5% on the balance unpaid and owed will be assessed each month until paid.

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at lease twenty-four (24) hours in advance to avoid a missed appointment fee of $50. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

DENTAL RECORDS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee of $10.

CONSENT & AUTHORIZATION: I authorize dental treatment on my self/child and agree to pay all related professional fees. Fees not covered or paid by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Fusion Children's Dentistry & Orthodontics. Without any reservations, I agree to abide by the policies outlined herein.

Name: _____ Signature: _____ Date: _____

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