Blowe Family Dentistry

FINANCIAL AGREEMENT

(Patient Name) _____ (Date treatment was presented) _____

Treatment: **Narrative Notes:**	# Broken/Fracture Decay Initial Placement PreviousPlacement Date of Placement	# Broken/Fracture Decay Initial Placement PreviousPlacement Date of Placement	# Broken/Fracture Decay Initial Placement PreviousPlacement Date of Placement	# Broken/Fracture Decay Initial Placement PreviousPlacement Date of Placement
ESTIMATE of total Charges:	$	$	$	$
DEDUCTIBLE Applied: (Minus)	$	$	$	$
PERCENTAGE of Benefits	%	%	%	%
ESTIMATED Insurance Payment	$	$	$	$
ESTIMATED Patient Amount:	$	$	$	$
Misc: **Nitrous Oxide**	$	$	$	$
Pre Payment or Credit Balance:	$	$	$	$
Balance Due:	$ +	$ +	$ +	$

Total Fee Charged For Tx: $ _____ **Total Fee Due At This Appointment: $** _____

Total Estimated Insurance Payment is based on limited information provided to us by your insurance company. Please be advised they may apply a UCR benefit which is a clause in a persons policy that states they will pay what the insurance company considers usual and customary fee. This is information when we call to get benefits is not provided to us by the insurance company.

Patient Portion is due full at time of service.

☐ **Option #1** (Payment Due In Full for Patient Portion The Day of Service if patient pays with **cash or check**)
We offer 5% discount on patient's portion if it is over $400 when payment is paid in full day of service.

Payment of $ _____ due at time of service.

☐ **Option #2 -** (Payment Plan with 2 payments with no interest charged for 14 days - for crowns, dentures, and bridges only)

1st payment is 50% of patient portion due on day of procedure of crown, dentures, bridges **1st payment - Prep Appt $** _____

2nd payment is 50% of patient portion due at seat of crown, dentures, or bridges **2nd payment -Seat Appt $** _____

☐ **Option #3 -** Our office is registered with Care Credit (Our patient may apply for a credit line from Care Credit at 800-365-8295)

As a courtesy to our patients we do accept assignment of benefit payments from most insurance companies. Our office is not a dental network provider for any dental insurance company. ***The information provided for you is an estimate*** *only based on the limited information provided to us by your insurance company. The patient portion is due at time of service as agreed upon above. The level of assistance purchased for you by yourself or by your employer determines the amount of your insurance company's payment. Please remember that your dental insurance is your responsibility. We are always happy to help you with submitting your claims, but* ***we can make no guarantee of payment by your insurance company.*** *Our office does not write off the amount that the insurance company does not cover. We will send a final statement if there* is any unpaid balance. Unpaid balances more than 30 days will be due immediately or considered a delinquent account to be handled by our *collections manager. If treatment is not started within 60 days of this agreement, all terms and fees are subject to change. Feel free to contact your insurance carrier for a more specific estimate. Treatment involving lab related work must be completed within 3 weeks or a remake charge* may be added.

If you have received treatment by another dentist or specialist it may change your estimate benefits
Cancellations with less than 24 hours may require a deposit for future appointments.

I have read and understand the financial estimate given to me and the financial options presented to me by Blowe Family Dentistry.

Signed _____ Date: _____
(Guarantor)

Signed _____ Date: _____
(Office Staff)