Russell Family Dental

Financial Agreement

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

All payments are due at time of service.

We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and American Express.

2) Flexible payment plans of up to 12 months upon approval with Care Credit®. Approval must be received prior to treatment.

If dentures, partial dentures, crowns and/or bridges, retainers, mouthguards or nightguards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, charges must be pre-authorized before the appointment date with the billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Payment of estimated patient portion is due at the time of treatment.

As a courtesy to you we will gladly process your insurance claim forms. We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. **All insurance co-pays and deductibles must be paid at the time of service.** Your complete insurance information must be presented at the time services are provided

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All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1 1/2% per month interest. I am responsible for all collection costs incurred by the dental office.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the Russell Family Dental Financial Agreement. I understand and agree to this Financial Agreement.

Signature of Patient or Responsible Party: