FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS FOR THE OFFICE OF DOCTORS ELAM, VAUGHAN, AND FLEMING

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best materials and technology currently available. We are also committed to providing you with up to-date information and educational tools so that you maintain optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your estimated co-payment may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. In addition, we offer outside financing available through Care Credit.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement at the end of this document. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. The following provisions identify our policies governing insurance claims, payment, and cancellation/missed appointments:

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- **Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Your portion of a new balance is due within 25 days of the monthly billing date. If your account is not made current in 25 days, a 1.5% late charge will be assessed each month. If you are unable to keep your account current, we may be unable to provide additional dental services except for dental emergencies or where additional services are prepaid. In case of default on your account, you agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on your account balance and any future outstanding balances.**
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- You will be charge for missed appointment or appointments that are not cancelled or rescheduled within 48 hours of the appointment time.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS FINANCIAL AND ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

____

Print Name of Patient/Responsible Party

____

Signature

____

Date