



FINANCIAL AGREEMENT

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they individually have purchased, will pay for all their treatment. This is incorrect and untrue.

As a **courtesy** to our patients we are willing to complete insurance forms and submit a claim on your behalf, **we are not responsible for the outcome of the transaction.** Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement.

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 and gives us your permission to release information to the insurance company.

We require you to pay the estimated co-payment, at time of service. In the event your insurance company fails to pay for treatment you received **YOU ARE RESPONSIBLE for the entire balance to be paid within sixty days of your visit.** You would then be responsible for seeking reimbursement from your insurance company.

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.

A fifty dollar deposit may be required to schedule your next dental appointment if you do not give a 48 hours notice prior to canceling or rescheduling any dental appointment.

Payment Options:

Extended Payment Option

Cash or Check (returned check fee \$25)

Care Credit

Visa, MasterCard, or Discover

Medical Bureau of Pittsburgh

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

Print Name of Patient/Responsible Party

Date _____

Signature of Patient/Responsible Party