



Payment and Consent for Services

- Please note that our office will do our best to maximize your insurance benefits. Amounts not covered or denied by your insurance will be your responsibility and either due at the time of service or upon receipt of a billing statement
- Our office will proudly present an estimate for treatment and an estimated portion that your insurance will not cover. Please let us know if you are not aware of the amount that will be due at time of service and we will be happy to supply you with this information.
- Our office will send you a billing statement with the amount due if there should be an outstanding balance after insurance has paid for services.
- A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days. If after 90 days, your account will be turned over to a collections agency or credit bureau. You would then be responsible for any legal fees.
- We appreciate that our patients' time is extremely valuable, as is ours. Please respect others by arriving to appointments as scheduled.
- Please provide our office two business days notification should you need to cancel so that we are able to make this time available for other patients. If sufficient notification is not provided you may be subject to a broken appointment fee. A minimum \$35.00 cancellation fee may apply.

I have read, understand, and give my consent to the above conditions of payment and consent for services.

Patient Name Printed: _____ Date _____

Patient Signature: _____