FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible dental care. It is our goal that you understand your treatment needs, as well as your financial responsibility before treatment begins. We strive to accurately predict the cost of your dental care and work with your budget. If you have insurance, we want to help you receive your maximum allowance benefits. To provide you the best possible experience, we ask for your assistance.

We will file the necessary paperwork to bill your insurance company for your dental treatment we ask that you please provide us with accurate information at the time of your appointment.

We request payment in full at the time of service, if you do not have insurance coverage unless other financial arrangements have been made in advance.

We ask that the parent bringing a child to the practice be prepared with co-payments or full payment at the time of treatment regardless of custody agreements.

We ask that you pay by cash, check or credit card for all estimated co-payments at the time of treatment. We are happy to help you secure financing from our available options.

AGREEMENT OF FINANCIAL GUIDELINES

I request and authorize Dr. Adkins to provide me the dental care. I understand that I am personally responsible for the charges for the services I receive.

I agree to make full payment for services I receive. I understand that regardless of dental insurance benefits, any treatment I receive is my financial responsibility.

I hereby authorize Dr. Adkins at his discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to Dr. Adkins.

Your signature below will acknowledge that you have read and agree to our financial guidelines.

Signature _____ **Date** _____