Financial Agreement

Pediatric Dentistry of Flower Mound
2701 Old Settlers Road
Flower Mound, Texas 75022

972.724.1617
www.pdofm.com

_____ • Payment: Payment is expected in full for each appointment as services are rendered. Payment options are:
- o Cash
- o Check
- o Credit Card (MasterCard, Visa, American Express, and Discover)
- o Care Credit (6 & 12 - month Interest Free Financing Available on approved credit.)

_____ • Dental Insurance: Dental insurance is a contract between you and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied" or "over UCR. Our office is not notified when there is a change in coverage or plan design. It is your responsibility to notify our office of such changes. We will file your **primary** dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you.

_____ • Missed Appointment Fee: Our office requests 2 business days notification if you are unable to keep your scheduled appointment. If less than 2 business days' notice is given, a $50 fee may be charged to your account. Patients with 3 missed appointments may be asked to transfer records to another doctor.

_____ • Emergency/AfterHours Appointment: If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid for in full at the time of service.

_____ • Returned Checks: There is a minimum fee of ($35.00) for any checks returned by the bank.

_____ • Monthly Statement: To reduce costs we do not "bill" for services rendered, payment is due and expected on date services are rendered. If you have a balance on your account after insurance has been paid or denied payment, we will send you a statement. It will show the previous balance, any new charges to the account, finance charge, if any and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

_____ • Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

_____ • Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ • EffectiveDate: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

The agreement is between Pediatric Dentistry of Flower Mound, and its Associates, and the Patient/Debtor named on this form. In this agreement the words "you," your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we," "us," and "our" refer to Pediatric Dentistry of Flower Mound. By executing this agreement, you are agreeing to pay for all services that are received.

_____
Patients Name

_____
Parent/Legal Guardian/Responsible Party (Printed)

_____ _____
Parent/Legal Guardian/Responsible Party (Signature) Date