FINANCIAL AND ASSIGNMENT OF BENEFITS AGREEMENT

Our financial agreement is intended to facilitate excellent service to you while minimizing our administrative costs.

Patients with Dental Insurance: All charges you incur are your responsibility regardless of your insurance coverage. We provide an estimate for all procedures; however, we cannot guarantee your insurance will provide 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. As a courtesy to you we will process your insurance claims.

X-Ray/Records Release: There is a fee of $15.00 for any release of x-rays and/or records per patient.

Payments: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover.

Broken/Rescheduled Appointments: Our office reserves the right to charge $50 per half hour for broken appointments and appointments rescheduled without 2 business days advance notice. We make every attempt to remind patients of their appointments but ultimately it is the patients' responsibility to keep their appointments.

Returned Checks: Returned checks are subject to a $40.00 insufficient fund fee per occurrence and balances older than 120 days will be subject to collection fees and finance charges.

Minors: Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-paid to a credit card or other payment arrangements have been made.

Authorization: I authorize the use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Potomac Dental Centre to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Potomac Dental Centre. I permit a copy of this authorization to be used in place of the original. I give Potomac Dental Centre, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Date:_____

Name:_____ Signature:_____

Relationship to Patient:_____