Insurance information for patient covered by dental insurance:

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber Employer: _____ Subscriber Id: _____

Insurance Name:_____ Group Id: _____

Financial Information / Terms & Conditions

This statement is to inform you of our financial policy. We are committing to providing our patients with the highest quality dental care using only the best material in dentistry today. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

As a condition of treatment by this office, fees must be paid at the time the service is performed. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with our patient not your insurance company. As a courtesy to you, we will help you process all your insurance claims. The office will accept assignment of benefits providing you pay all co-payments and patient deductibles at the time of the office visit, any insurance payment not received within 45 days from the date of service will be charged to your account, we accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Payment of your portions of the charges, whether a part or the total amount, is due at the date of service, unless other specific arrangements have been made prior to treatment, Our office accepts cash, personal checks Master Card, Discover, Visa, Money Order, Care Credit and Bank Checks, **Returned checks** are subject to a $50.00 fee. **Balances over 60 days old** become sole responsibility of the responsible party, even if the insurance benefits are expected. Additionally, our office will charge a fee of $40.00 for **broken appointments** and **appointments cancelled** without 24-hour advance notice.

By signing below, I understand and agree to the terms described herein and agree responsibility for the payment of services. I agree to pay all costs incurred by my failure to remit for services rendered, including fee charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this for. Furthermore, I authorize the dental benefits otherwise payable to me to be paid directly to Epic Lifetime Dental Care. I have read the above conditions of treatment and agree in content.

Signature: _____ Date: _____

Printed Name:_____