PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____ ("patient")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company **AS MY INITIAL PATIENT PORTION TODAY IS ONLY AN ESTIMATE**. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I acknowledge that the practice may have a small balance/credit write-off policy, where permitted by law, and that these balances may be reduced to zero.

_____ I understand that the Practice may charge the following items:

(Initial)

1. A fee for each appointment that is consistently missed/cancelled without at least 24 business hours advanced notice.
2. An amount equal to $25.00, but not to exceed the maximum amount permitted by law for each returned check
3. A late fee if payment on my account is not received by the due date

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

As a guarantee of payment, Shaenfield Family Dental will keep debit/credit cards on file. Cards will only be charged after the visit has been billed to insurance and a balance is indicated. Before charging your card, we will send out a monthly statement allowing you the opportunity to resolve any payment concerns with your insurance carrier. Your card will only be charged if there is no response to our bill.

By signing below, I authorize Shaenfield Family Dental to charge my debit or credit card on file for any balance not covered by my insurance.

Signature of Responsible Party:_____ Date: _____

(to be signed even if Patient is also the Responsible Party)