Financial Agreement

This agreement is to inform you of your financial obligation to Syringa Dental Care. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. If your treatment requires the use of a dental lab (crowns, bridges, partials, dentures, etc.) **50%** of your estimated fee **IS REQUIRED** on your first treatment appointment. For those patients without dental insurance or on *True Blue* insurance, Syringa Dental Care offers a 5% discount on services paid in full at time of service (cash or check payments only). For *True Blue* insurers, this discount will be for non-covered services. For services exceeding $750.00 a payment plan will be required prior to the start of the dental treatment.

Dental Insurance: As a courtesy to you, we will be happy to complete and forward insurance forms relative to your dental treatment, and will do so at no charge. To serve and assist you in utilizing your dental insurance, Syringa Dental Care accepts assignment of benefits from your insurance company. It is your responsibility to provide us with the correct subscriber ID number and the correct mailing address of your insurance carrier. Please keep in mind that our professional treatment is rendered to you, NOT your insurance company. Therefore, ultimate responsibility for payment is yours. The determination of what benefits are allowed is a negotiation between your employer and the insurance provider. If you have any questions about the amount the insurance plan will pay or the treatments your plan will cover, you should refer these questions to your employer. At your request, this office will provide all pertinent information to your insurance company and we will do our best to help you derive the maximum benefits available.

Your ***estimated*** co-payment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Our practice accepts cash, personal checks, MasterCard, and VISA. We also offer CareCredit, a healthcare credit card specifically designed to pay for treatments and procedures not covered by insurance. You can use the card at all healthcare practices that offer CareCredit.

Returned checks, bank fees and balances older than 90 days will be subject to finance charges at the rate of 1.5% per month (18% annually).

I acknowledge and agree that I may be required to pre-pay for the next appointment if I have missed two or more appointments in the last twelve months. A missed appointment is considered to be one that I do not keep or do not cancel within 48 hours of its scheduled time.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

_____ Date ____/____/_____

Signature of Patient or Responsible Party

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