Financial Agreement

Effective January 1, 2016

In order to help maintain a good relationship with our patients, Infinity Dental, PLLC, has a written financial policy, this assists with minimizing and eliminating misunderstandings. Our office communicates this policy to each patient.

1. **Payment Expectations:** Pre-payment or payment at the time of service is required. For your convenience, Infinity Dental, PLLC accepts the following credit cards: Visa, Master Card, Discover, American Express, and bank Debit Cards. Payment with cash or personal check is always welcome.

2. **Payment Options:** Infinity Dental, PLLC offers interest free payment options (up to 24 months) with approved credit through the "Care Credit" and other 3rds party programs. Please inquire about these options if interested.

3. **Estimates:** If you have any questions regarding the cost of your dental treatment, please do not hesitate to ask for a written estimate. Note: Said estimate is only an estimate. Circumstances may arise which require more or less treatment and thus may result in a change of treatment estimate.

4. **Delinquency:** Your account will be considered delinquent if payment is not received within 60 days from the time of service; a late fee of 1.5% per month will be assessed and will appear on any subsequent statements. The annual percentage rate is 18%.

5. **Returned Checks:** Any checks returned to our office due to insufficient funds will be charged a minimum $50.00 fee. In addition, late fees will accrue at 18% per annum from the date of service. Infinity Dental, PLLC, reserves the right to contact the district attorney's office and seek legal redress if attempts to remedy the situation are not made in a timely manner.

6. **Collections:** Delinquent accounts will be sent to a collection agency, and collection fees of up to 50% of the balance due to cover such fees will be added to your account. If the balance is deemed uncollectible by the agency after 30 days, a report will be filed with the three national credit reporting agencies, which will adversely affect your credit rating.

7. **Insurance:** For our patients with dental insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy to you, ***the insurance contract exists between the carrier and the insured party, namely the Employer***. This contract situation varies from employer to employer and may include co-pays, deductibles, allowed benefits, and maximum annual benefits. Please contact your insurance handbook for details. It is also your responsibility to know what your ***eligibility dates and effective dates*** are. In addition, insurance companies reserve the rights to refuse payment for ANY reason, including the language, "not medically or dentally necessary." This 3rd party opinion by the insurance company may differ from that of your dentist or hygienist. **Our primary concern is your dental health – i.e. we do not base our recommendations for any treatment based on your insurance coverages, but on what is best for you and your health.** Insurance companies have other considerations, not always necessarily what ideal patient care is. If this is the case and the insurance company refuses payment or gives only partial payment for services rendered, you will be responsible for full payment. We have no way of knowing for certain that an insurance company will pay for services rendered and opinions may differ. We attempt to work with your insurance company to help maximize dental benefits, but there is absolutely no guarantee that we will be successful. If for some reason we do not receive payment from your insurance company with in 30 calendar days, you will be sent a statement that is due and payable upon receipt. After 60 days from time of service non-payment will be considered delinquent. Infinity Dental, PLLC, reserves the right to terminate participation with any dental insurance program, for any reason, at any time without notification to patients. We urge patients to receive the treatment that is needed and not necessarily only treatment that is covered under your benefits or needed treatment if benefits have expired.

Authorization:

I have read and understand the financial policy of Infinity Dental, PLLC, and agree to the terms described therein. I hereby authorize payment to Infinity Dental, PLLC, for the group insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. My signature below indicated that that I accept the terms of this financial agreement including permission to release my information in the event a collection agency or the district attorney's office becomes involved.

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Signature of Patient, Parent, or Responsible Party