QUINLAN PARK™

DENTAL

FINANCIAL RESPONSIBILITY FORM

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update Quinlan Park Dental at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Quinlan Park Dental.

We will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will attempt to appeal the claim. All insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for treatment is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees. Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $25 NSF check fee.

We request a 48 hour cancellation notice for scheduled appointments. **A cancellation fee of $50 may be charged if a 48 hour notice is not given.**

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all terms and conditions herein.

_____ _____/_____/_____

Patient Name (print or type) Date

_____

Signature of Patient or Responsible Party/Relationship