

Commitment to Financial Agreement

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment:

- A. **Payment is required in full by cash, check, credit card, or alternate financing for each appointment before services are rendered.** Please be advised that if a check is returned due to insufficient funds, your account will be charged a \$40.00 returned check fee. A social security number is required from all patients if not paying by cash or if we are filling an insurance claim for you. This information is kept confidential and used for collection purposes only.
- B. We will file your insurance claim form and accept payments from your insurance company, provided the deductible and any estimated non-covered fees are paid at each visit.
- C. We allow up to 60 days for your insurance company to pay your claim. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 3 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for service rendered. We will gladly assist in any way we can. In the event this account becomes delinquent and past due, owing more than 30 (thirty) days from the date of billing, I hereby agree to pay all costs of collection including, but not limited to interest, court costs, service of process fees, reasonable attorney's fees and collection costs as may be necessary.
- D. We value our patient's time therefore we make every effort to see our patients at their appointment time. We appreciate the same courtesy from our patients, therefore, if you cannot make your appointment please call us at least 48 hours ahead so that we have the opportunity to schedule another patient. *If you do not show up for your appointment without calling our office, there will be a \$40.00 "Broken Appointment" fee added to your account.*
- E. A parent or guardian must accompany patients under the age of 18 years old.
- F. Family Dentist of Palm Beach, Inc. reserves the right to charge for duplication of records.
Duplication of x-rays cost \$30.00.

Please be aware that any parent or guardian bringing in a child to our office is legally responsible for the payment of services rendered.

We appreciate the opportunity to serve you, our valued patient.

Patient or Responsible Party

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I have received and read a copy of the office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

