STIEBEL&BAKER DENTISTRY

FINANCIAL AGREEMENT

We are pleased that you have chosen our office to help you with your dental needs. We strive to maintain quality dentistry in a compassionate and friendly atmosphere and we look forward to the opportunity to serve you.

Normal policy requires payment in full at the time of service. All other options must be pre-arranged with the financial coordinator prior to treatment being rendered.

Many patients have insurance that will usually cover **a portion** of their costs of treatment in our office. As a courtesy, we are happy to file your claims with your dental insurance carrier. Our staff is dedicated to helping you maximize the benefits that you receive from your insurance carrier. It must be understood, however, that you will be personally responsible for any balances not covered by your dental insurance company.

If your insurance company has not made a payment within 45 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company, your employer, and you.

We ask that you pay the estimated co-payment and any deductible at the time of service.

All outstanding balances will be considered overdue if not paid in full within 90 days. You will be responsible for the total balance due and any additional costs related to the collection of these balances.

I authorize Dr. Christine M. Baker or her agent to apply for benefits on my behalf for rendered dental services and request that payments from my insurance company be made directly to Stiebel & Baker Dentistry. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above agent. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either party at any time and must be submitted in writing.

<u>If signing this financial agreement for a minor child's account, you are agreeing to be the financially responsible party for all treatment provided in this office for this child.</u> Any other existing agreement regarding the financial responsibility for the child's care (divorce decree, etc.) is separate and must be worked out by the adults involved in such an agreement. The financially responsible party is accountable for any money owed to the practice regardless of which guardian brings the child to the appointment.

I authorize the following people to consent for my child's dental treatment:
Names: _____
If withdrawn, we must be notified in writing. This adult must present with the child for the duration of the dental visit.
Ex: caregiver, grandma, etc.

_____	_____	_____
Printed Name	Signature	Date