Sweet Tooth Dental Center Financial Agreement

Your estimated out of pocket cost for treatment is approximately $_____ is due prior to treatment, unless a payment plan has been established. If applicable, we will bill your insurance for the remaining balance. If the insurance mistakenly sends the check/payment to you, the patient, that payment is due to our dental practice within 10 days, unless otherwise agreed upon. If your insurance carrier pays more than anticipated and you have already paid an amount toward your treatment that exceeds your final patient responsibility, we will reimburse you for the overpayment. Failure to forward any payment due in a timely manner may result in a third-party collection process. Since the appliance is custom-made, it is non-refundable. Although we cannot provide refunds, we strive to provide the best product, using the knowledge, skills and materials at our disposal. As a courtesy to you, we have verified your insurance benefits to confirm that this is a covered benefit. Please understand that our verification of benefits does not guarantee your insurance payment. If for any reason your insurance carrier(s) should fail to pay for certain services, due to loss coverage or other circumstances, you will be responsible for any unpaid charges. It is your responsibility to provide us with current medical insurance and if your medical insurance changes or terminates at any time, please notify us immediately. We will file all necessary pre-authorizations needed to minimize your out of pocket expense. Some insurance companies require the patient or the patient's primary care physician call and request pre authorizations. If this occurs, we will assist you and/or your primary care physician with this process.

Estimated out-of-pocket cost (office use): $

I have read the Financial Agreement above and agree to the terms therein. Provider:

Printed Name of Responsible Party:

Signature of Responsible Party: Date: