Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available on the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service while minimizing our administrative costs.

All charges you incur are your responsibility from the date services are rendered, regardless of your insurance coverage. **We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.** Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. However, our office will continue to file your dental claims to your insurance company as a courtesy, with the benefits payable to you. This is a service we are happy to provide for our patients and we will work hard to ensure you are able to use your benefits to the fullest extent. In order for our practice to file your insurance claims, you must bring a copy of your insurance card and update the front office team with any changes.

All payments for treatment are due at the time of service. Our practice accepts cash, personal checks, Visa, Mastercard and Discover payments as well as third party financing through CareCredit and Proceed Finance. Complete Dentistry also extends a discount for payments made at the time of service. For cash and check payments we extend a discount of 5%, Visa/Mastercard Payments 4%, and Discover Payments 3%. For larger treatment plans and Invisalign we do customize in-office payment plans depending on the length of treatment. If you have any questions about this information, do not hesitate to ask our front office team. **WE ARE HERE TO HELP YOU**.

I understand and agree that (regardless of my benefit company or plan) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information noted above. If my account goes unpaid, I understand I will be responsible for a one-time charge of 35% collection fee as allowed in the State of Kentucky.

Patient Name Printed: _____

Signature:_____ Date:_____

Complete Dentistry for All Ages

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