FINANCIAL AGREEMENT

with

THE DENTIST'S HOUSE OF EDINA

"a comfortable approach to dentistry"

PLEASE have filled out by THE RESPONSIBLE PARTY
(This individual must be over the age of 18 and if required, be a parent and/or guardian)

WELCOME! *It is our intention to provide your dental health needs as thoroughly and as efficiently as possible. Our fees are usual and customary for this area.*

Financial Agreement: We welcome and encourage a frank discussion of your financial investment in your dental health. An explanation of the recommended treatment and the ***estimate*** *of fees involved will be presented to you for acceptance. Payment is due at time of service unless other arrangements of been made* ***prior*** *to the reserved appointment time. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility will be determined* ***prior*** *to treatment.*

Statements: If any payment is made to your account, The Dentist's House of Edina will provide a statement showing services, payments and credits made to the account. Also, the statement will include the amount owed and date due if a payment is needed. The statement will be considered correct unless notified. Please contact us before the date due for payment if you have a question. We will investigate your question(s) and upon conclusion, immediate payment is due if necessary.

Finance Charge: The Dentist's House of Edina will charge a Finance Charge for each day the account is not paid by the due date. There will be no Finance Charge if financial arrangements for the account to be paid in full have been made. The periodic rate that will be used to figure the Finance Charge is 1.5%, corresponding to an annual rate of 18%. This rate will be applied to the amount owed at the end of each billing cycle.

Rights if in Default: The Dentist's House of Edina will accept late payments, partial payments or any payments marked as being paid in full or as being in settlement of any dispute without losing any of your rights under the law. The responsible party assumes full responsibility for payment of services, finance charges, collection and/or attorney fees required in the collection of this account.

Please make your intentions for payment of services rendered by choosing one of theses options:

____ *Full payment with cash, personal check or charge to my MasterCard, Visa, American Express or Discover Card.*

____ *Charge on Care Credit (upon approval). Please contact our office before your scheduled appointment for this financial arrangement option.*

In consideration of services provided: By signing this form I am the responsible party agreeing to pay for services provided to me, or to my spouse or to my minor children/dependent list below:

_____ _____

_____ _____

If you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make ***every effort*** *to avoid a misunderstanding and preserve a friendship.*

Date _____ _____
Responsible Party Signature

_____
Please Print Responsible Party's Name

(continue if you have Dental Insurance)

Most insurance plans do not pay for the entire cost of your dental care. Your policy may include one or more of the following limitations:

1. *a deductible clause*
2. *a co-payment provision*
3. *a dollar limit on covered services*
4. *not all services covered*
5. *a co-insurance clause*
6. *a table of allowances*
7. *and others…*

We suggest that you determine which of these limitations apply to your particular contract. Insurance plans vary considerably. We highly suggest you research the benefits to which you are entitled under the provisions of your contract and ***allow us to do research for you as well.*** *We will assist you in maximizing your dental benefits as needed for your dental health. Our office provides dental services for patients with a great variety of insurance programs and we usually can obtain the needed insurance information with your assistance.*

In the event that you do not receive the benefits to which you believe you are entitled from your insurance carrier, we suggest you contact your insurance representative, your union agent or the following agencies: The State Insurance Department; the Attorney General's Office; or your local consumer protection agency.

Financial Policy for individuals with Dental/Medical Insurance: *I understand that my insurance policy is a contract between my insurance company and me. As a service to me, The Dentist's House of Edina will file my insurance form(s) at no charge. If the insurance company does not pay my claim within 30 days after it is mailed or sent as an electronic claim, The Dentist's House of Edina will assist me in the claim settlement. However, I understand that my account is always billed to me and that I am personally responsible for payment of my account. If I do not pay my account The Dentist's House of Edina will treat it as a loan under this agreement, subject to finance charges.*

If we file insurance for you:

a. *Please provide your dental insurance card for your first visit. We will make a copy of your card and call your insurance to verify your benefits and to the best of our ability, maximize these benefits as a courtesy. However, you are overall responsible to understand your insurance benefits.*

b. *The payment is expected in full for each visit and we will complete your insurance claim, submit and provide you a copy upon request.*

c. *You should receive payment from the insurance company. If payment is mistakenly made to The Dentist's House of Edina, we ask you to contact The Dentist's House of Edina for the details on your account.*

Release of Information: *I authorize The Dentist's House of Edina to release written, verbal or radiographic dental/medical information for the requested dental/medical reports and/or insurance processing for me, my spouse or for my minor children.*

Date _____ _____

Responsible Party Signature

_____

Please Print Responsible Party's Name