Financial Agreement

We consider it an honor that you have chosen Franklin Dental Associates for your dental needs. It is our philosophy to be informative, honest and forthright with our patients. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have questions or concerns about our Financial Agreement, please do not hesitate to ask our front desk team.

Dental Insurance:

As a courtesy, we will gladly file your claims and accept assignment of dental insurance benefits, provided you agree to the following:

- You must provide us with a photo ID, an insurance card and all necessary information to verify your policy.
- Your insurance policy is a contract between you, your employer and your insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers “Usual and Customary” unless we are considered a participating in network provider of said insurance.
- Although we may estimate your insurance benefits, based on the information your insurance company representatives choose to share with us, we are not responsible for their accuracy. Knowledge of benefits as well as benefits maximums, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.
- All charges not paid by your insurance company are your responsibility, regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

Payment Policy:

We accept cash, personal check, debit cards and most major credit cards as well as Care Credit.

Patients with Insurance:

As previously stated, we will file your dental insurance claims for you, and we accept assignment of benefits for insurance plans we are in network with. You are responsible for paying any expected copayments or out of pocket expenses at the time of service.

If your insurance does not pay within 30 days, it is your responsibility to pay the balance due within two weeks. We will mail monthly statements to all patients with an outstanding balance charge of 18% per annum after 45 days.

Patients without Insurance:

Whenever possible, we provide an estimate of fees for needed treatment and payment is expected at each visit for services rendered.

All Patients:

Please note, for procedures requiring more than one hour of chair time, more than one appointment, we ask that payment be paid in full at the start of treatment or half of the expected copayment be paid at the first scheduled appointment with the remainder of the copayment due at the next scheduled appointment unless other arrangements have been made.

Minor Patients:

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorce or separated parents, the parent accompanying the child is responsible for payment, with no exception. Payment is due at time of service, regardless of divorce decree.

Returned Checks:

A $35.00 charges applies when a check is returned by the bank.

Overdue Balances:

An account with an unpaid balance past 90 days will be sent to our collection agency. At that time, additional fees will be added to your account, to cover any charges incurred by us for assistance in collecting your debt (collection agency fees, attorney fees, etc.)

We do understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

Consent and Authorization:

I authorize dental treatment for myself (or minor child) and agree to pay all related professional fees. I agree to pay any estimated copayments at the time of service. I understand that I am financially responsible to pay any insurance claims denied by my insurance company, regardless of the reason. I understand my insurance is my responsibility, and I do not hold Franklin Dental Associates responsible for any errors or omissions made by my insurance company.

I have read and understand this document in its entirety, outlining office policies and financial policies of Franklin Dental Associates.

Form Completed by:

Name: (please print) _____

Signature: _____Date: _____