

Morgan Dental Care

Welcome! The purpose of this agreement is to clarify your and our financial responsibilities so we can devote our efforts to helping you achieve and maintain the healthy smile you desire.

FORMS OF PAYMENT:

Patients are responsible for full payment at the time of service. We accept cash, personal checks, MasterCard, Visa, Discover, American Express, Debit cards and our own outside financing. There will be \$25 service charge on all returned checks.

APPOINTMENTS:

There will be a broken appointment fee for cancelled/broken appointments, without a 48 hour business day notification, that equals 1/2 of the fee of your scheduled treatment. For appointments 2 hours or longer, we ask that you make your payments prior to your reserved appointment.

INSURANCE:

All professional services rendered are the responsibility of the patient. As a courtesy to you, if you have dental insurance, we will file your insurance claims, *although you are responsible to us for all charges incurred, not your insurance company.* Your claim is filed the day of your service. We will provide your insurance company with all of the information necessary for them to process your claim. If your insurance company denies your claim or takes longer than 60 days to pay, we ask that you pay your balance in full and collect the money due from your insurance company.

BILLING:

We do not bill. We ask that our patients not have a personal outstanding balance. The only balance on your account would be expected from your insurance company for up to 60 days. If your Ins. Co. hasn't paid your claim after 60 days, we ask that you pay your balance in full and collect the money from your Ins. Co. Any balance over 60 days, will be subject to interest charges of 1.5% per month, plus any legal or collection fees.

FINANCIAL ARRANGEMENTS:

In order to help you obtain the dental health you desire we have financial options that will let you make monthly payments, in some cases interest free for up to a year. We also offer pre-payment discounts for treatment plans over \$250 when they are paid in full when you are making your appointment or at least 2 weeks prior to your appointment.

I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THIS FORM:

Signature _____ Date _____