

## **Swisher Dental Financial Agreement**

**Thank you for choosing Swisher Dental for your dental health needs.**

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so, we would like to explain our financial options. Please choose the option that works best for you.

1. Payment is due at the time treatment is rendered. We accept Cash, Check, Master Card, Visa, Discover, and CareCredit.

2. Dental Insurance – As a courtesy to you we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. \_\_\_\_\_ (please initial)

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

3. Monthly payment options – If you need to make long-term payments we can offer financing with CareCredit which offers up to 12 months NO INTEREST financing as well as longer terms with low interest rates. You must qualify for this option. Please do not hesitate to ask us about this option. We may conveniently qualify you right here in the office today.

4. We can offer a three-month payment plan with a credit card on file.

Minor Patients – The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

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Statements – All patients with an outstanding balance will receive a statement each month. There is a charge of \$5.00 on all accounts 60 days overdue. All accounts over 90 days will be subject to our collection agency.

Returned Checks – A fee of \$25.00 will be charged for any returned checks.

Broken Appointments – Our practice may charge you \$25.00 for appointments broken without proper 24 hour weekday notice. We understand that emergencies occur. However, we want to make the appointment available for other patients.

I assign directly to Swisher Dental, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Swisher Dental to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay. Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please let us know.

\_\_\_\_\_  
Print Name of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party