Treatment Agreement:

We are committed to providing dental therapy that addresses the patient's special needs, concerns, and problems. We strive to make the overall experience as pleasant as possible. We expect that the patient will take an active role in his/her care. This means that the patient promises to ask questions whenever needed in order that they may better understand the recommended treatment, the recommended instructions prior to treatment and any instructions give following treatment. This will help to maximize treatment results and your overall dental experience.

Patient Responsibilities:

-Be courteous and professional to Doctor & staff
-Keep all scheduled appointments **(At least 48 hour notice is required to cancel/reschedule or $50 charge may apply)**
-Pay for treatment at the agreed time

Financial Policy:

We are committed to providing you with the best possible care. In order to achieve this goal we need your assistance and your understanding of our payment policy. Payment for services is due on or before the day services are performed unless other arrangements have been made and approved in advance by the Financial Coordinator. We accept Cash, Check, Credit Card, and CareCredit. Financial arrangements will only be made with a credit card on file and on case by case bases. Funds will be drafted each month on the agreed date.

If Insurance Is Involved:

We will file claims on your behalf in most cases. Please understand that this is a medical facility and our doctors care about your health. It is their responsibility to advise you of the status of your dental health and advise you of treatment needed based on your specific needs not based on your insurance coverage.

Secondary Insurance:

● If you have secondary dental insurance we will bill the secondary company. Once both insurance companies issue payment any remaining amount due will be due from you. Please check your secondary coverage for a Non- Duplication Clause.
● As personal account payments come in, we apply those payments to the head of the household, not the individual patient. The account balance is a "Family Running Balance" due, not an individual's balance due. We encourage you to read your "Explanations of Benefits" issued for payments from your insurance provider.

Divorced Parents:

● If the patient being seen is from a divorced family, the parent who brings the child to the appointment is responsible for providing the correct Insurance information and the payment of services. A receipt will be provided.

Please Be Advised:

We bill your insurance as a courtesy to you. However we do not take responsibility for your insurance plan, their fees, allowances, limitations and specifications. There are hundreds of insurance plans and it is impossible for us to know them all. Therefore it is the patient's responsibility to know and understand their individual plan. If you have specific questions about your plan you should contact your insurance directly.

WE WILL DO OUR BEST TO ESTIMATE WHAT INSURANCE WILL PAY AND WHAT THE PATIENT PORTION WILL BE FOR YOUR TREATMENT. THE ESTIMATED PATIENT PORTION WILL BE DUE AT THE TIME OF TREATMENT. ANY AMOUNT NOT PAID BY YOUR INSURANCE, REGARDLESS OF THE REASON, IS YOUR RESPONSIBILITY.

Terms & Conditions:

I, the undersigned, agree to all financial policies as listed above.
All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for by one of the above mentioned methods of payment the day services are performed.
I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
Assignment of Benefits: I herby authorize my insurance company to pay directly to my dentist, benefits accruing to me under my policy. I hereby authorize Desert View Dental staff to make insurance inquires on my behalf to insure proper handling and payment of all claims.
If any balance becomes delinquent over thirty (30) days, Desert View Dental will impose a late payment charge of 1.5% per month (or maximum allowed by law). It is further agreed that I will be responsible for the attorney's fee and any other related costs for collection in the event that this account requires collections. There is a $35.00 charge for all returned checks.

______________________________	______________________________
Name of Patient	Name of Responsible Party
______________________________	______________________________
Signature	Date