

# FINANCIAL AGREEMENT

## Fay Dental Care

I will be responsible for any financial obligations incurred in connection with dental treatment rendered at FAY DENTAL CARE. I understand that payment or patient portion must be made at the time services are rendered. I will also be subject to finance charges for unpaid balances after 30 days.

I further understand that I am responsible for any charges incurred at FAY DENTAL CARE which are not covered by my dental insurance. Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

Please provide 24 hours prior notice to cancel or reschedule an appointment with FAY DENTAL CARE. We do charge an appointment fee of \$40 for any missed appointments in the event 24 hour notice is not given. If siblings are scheduled same day and one family member needs to reschedule, please notify our office in advance so we may offer the appointment to another family.

**SIGNED:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**DATE:** \_\_\_\_\_