# Baker & Graham

FAMILY DENTISTRY

## FINANCIAL GUIDELINES

_______ I understand that payment is due at the time service is provided. Our office accepts cash, personal checks and all major credit cards. Outside financing is available upon request and approval. Please let us know if you would like more information about financing options.

_______ I understand that a finance charge of 1.5% monthly up to 18% annual interest will be added to my account monthly if my account is delinquent . I understand, that if not paid, my account will be turned over to the Credit Bureau and I will be responsible for all collection costs, court costs, attorney fees, and any additional delinquent billing fees or processing fees.

_______ I understand that returned checks will be subject to additional fees

## AUTHORIZATION TO DISCLOSE PROTECTED DENTAL INFORMATION AND ACCOUNT INFORMATION

I authorize Baker & Graham Family Dentistry to discuss my dental treatment and/or my account information with the following:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
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## INSURANCE PATIENTS

_______ I understand that Baker & Graham Family Dentistry is an Out of Network Provider with my insurance company.

_______ I have presented my insurance benefit card to the receptionist.

_______ I agree to pay the estimated amount not covered by my insurance company at the time of my service. I understand that this is an insurance estimate and it is not a guarantee that my insurance will pay exactly as estimated. My insurance company and my plan benefits ultimately determine the amount paid. I understand that I am responsible for any remaining balance within 30 days after my insurance company pays my claim.

_______ I understand that all charges incurred for me and my dependents are my responsibility regardless of my insurance coverage. I understand that you are my dental care provider and your relationship is with me and not my insurance company. My insurance policy is a contract between me, my employer, and my insurance company. Your office is not a party to that contract.

_______ By signing this form, I instruct my insurance company to pay directly to your office.

## I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS

PATIENT SIGNATURE OR PARENT OF CHILD _______________ Date _______________