Mills Park Dental, P.A.

Financial Policy Agreement, Assignment of Benefits and General Authorizations

Thank you for choosing **Mills Park Dental** as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health.

Payment is due at the time service is rendered. Our office accepts personal checks, Mastercard and Visa. CareCredit financing is available upon request and approval.

Appointments: As a courtesy to our office and to other patients, we would like at least 48 hours prior to cancelling an appointment. This time is kept especially for you and we appreciate advance notification in order to plan your time. Any two consecutive cancellations or no shows will be charged a $75 fee.

Insurance

As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, and not with your insurance company.

At **Mills Park Dental** we are committed to providing the best treatment for our patients and as a patient you are responsible for payment. Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made a payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for the full amount at that time.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFTS DIRECTLY TO MILLS PARK DENTAL, P.A.

Patient Signature (Parent of Child)_____

Date_____