First Care Dental Associates, P.A.

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FINANCIAL AGREEMENT

Revised 11/19/2007

The following is a statement of our financial policy which we require that you read and sign before treatment begins. The responsible party must also provide a driver's license (or comparable picture ID) and an insurance card, if applicable, for copying.

TREATMENT COST ESTIMATES: The investment necessary to complete your dental treatment is an estimate based on information from your physical and radiographic examinations. Should additional problems arise as treatment progresses, this estimate may need to be revised. You will be informed before any unexpected treatment is undertaken. Where estimates involve dental insurance benefit coverage, please be advised that no insurance estimate can be guaranteed to be 100% accurate. Your co-insurance fee may exceed what your insurance carrier considers to be usual and customary. You may have used benefits prior to being treated in our office that we are not aware of. Your insurance coverage may change unexpectedly without notice to us. Ultimately, the amount paid by insurance is determined by the insurance carrier based on information that may not be disclosed to our office. Thus, estimated insurance payments and patient copayments are estimates provided as a courtesy only and are not binding. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.

NOTE: Most patients refer to a restoration as a filling. The category "restorations" includes fillings, inlays, onlays, and crowns. Fillings, inlays, and onlays are charged according to the number of tooth surfaces involved due to decay or defective restorations, as well as the required type of restorative material to be used. There can be as many as five surfaces per tooth (biting surface, front, back, cheek side and tongue side).

FULL PAYMENT IS DUE WHEN SERVICES ARE RENDERED: For your convenience, we accept the following forms of payment: Cash, Personal checks, and all major credit cards. **ADULT PATIENTS** (18 and older) are responsible for FULL payment at time of service. **MINOR PATIENTS** (Under 18) must be accompanied by a parent or guardian at all times. The adult accompanying the minor is responsible for full payment at time of service.

INSURANCE: All insurance coverage must be verified before treatment begins. As a service to you, we will complete and submit your required dental insurance claims; however we cannot bill your insurance company unless you provide us with your correct and complete insurance information. All fees will correspond to the dental insurance charge/payment schedule in effect on the date each procedure is initiated. Acceptance of insurance assignment by this office does not absolve the responsible party of full responsibility for the charges in full for treatment rendered. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be due and payable by the undersigned. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are payable prior to treatment being received. In the event your insurance coverage changes to where we are not a participating provider please refer to the above. Your payment responsibility may change if your dental insurance coverage changes. Again, any estimate provided by this office is considered a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make NO GUARANTEE of the insurance payment as estimated.

BROKEN APPOINTMENTS: Failure to notify our office at least 24 hours prior to a scheduled appointment of your need to cancel or reschedule said appointment will result in a broken appointment fee.

CHECK COLLECTION: Payment by check authorizes the initiation of a debit entry to your checking account at your bank for the amount rendered on the check plus an additional debit entry for the applicable collection fee, if the check is dishonored. Florida law designates that the following fees shall become payable on every check returned: $25—Checks under $50; $30—Checks $50 to $300; $40—Checks over $300. This authorization will remain in full force until we receive written notification from you in a reasonable time to act. Account balance and fee may also be paid by cash, cashier's check or money order within 7 days of return. However, if your account remains unpaid after 7 days following your check being dishonored, it will be turned over for legal prosecution.

DELINQUENT ACCOUNTS: Accounts 30 days or more overdue will be assessed an interest rate of 1.5% per month as provided by State law. Failure to keep your account current will also result in our inability to provide additional services for any patients included on the account unless treatment is prepaid by cash or money order. In the case of default on payment of the account, the undersigned will be held accountable for collection costs and attorney fees incurred in an effort to enforce payment as required by this agreement. Failure to sign this agreement does not negate the responsible party's financial responsibility for any services that have been rendered, as submission to treatment implies consent as outlined in this service agreement.

I certify that I have read and accepted all terms as set forth above and have received a copy of this agreement as of this date.

Signature of Responsible Party	*Date*	*Signature of Provider Representative*	*Date*