FINANCIAL AGREEMENT FOR CLEONA DENTAL, LLC

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

We will be happy to bill your insurance company on your behalf. However, all charges you incur are your responsibility regardless of your insurance coverage. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your **estimated** copayment is due at the time service is rendered and may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. If you are in need of more time to pay your balance, a third party, extended payment financing is available upon request and approval.

Our practice accepts cash, personal checks, MasterCard, Visa and Discover. There is a 6% discount for payment with cash or check for services that total greater than $1,000. Returned checks will be subject to fee of $25.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date