Wallace Family Dental

FINANCIAL AGREEMENT

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of lifetime dental care so that you may fully attain optimum oral health. **Everyone** benefits when office and financial policy agreements are understood. **Please understand that payment of your bill is considered as part of your treatment.**

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit. **Payment for services is due at the time services are rendered unless prior arrangements have been made.** If major dental work is required, it is understood that **at least half** of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. **Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.**

If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. **You are responsible for your entire bill regardless of what your insurance company pays**. **We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. The office cannot render services in the assumption your charges will be paid by your insurance company.**

Accepted Insurance
We accept and file most dental insurance plans, and are in network with **Cigna Dental, Delta Dental and Blue Cross Blue Shield of Arkansas**. Many times, insurance refuses to cover treatments and diagnostic procedures that dentists know are necessary for patient health. **For this reason, treatment will not be dictated by insurance reimbursement, but instead by the standard of care set forth by the American Dental Association**.

In consideration for the professional service rendered to me or at my request by the doctor, I agree to pay for services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. I have read and understand the above financial and office policy agreement.

Patient Signature _____ **Date** _____