Ballard Dental Associates

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Practice Financial Agreement

We know that everyone has different financial situations and concerns. That is why we have developed payment options to meet those needs. **Payments for services rendered are due at the time of service.** For our insured patients we will calculate the estimated patient portion, which includes deductibles, UCR differences, and services not covered by standard dental insurance. We will collect that amount at the time of service. As a courtesy we will assist you in filing your insurance claim, but because your policy is an agreement between you, your employer, and the insurance company, we are unable to guarantee payment for any or all services rendered, and can only estimate your initial out-of-pocket based upon our computer analysis of your insurance policy. Any balance remaining on the account after 45 days from the date the service was rendered is due and collectable, regardless of the insurance reimbursement.

Payment Options Available

We accept: **MasterCard, Visa, Discover, Personal Checks, or Cash**

We also accept: **Care Credit for those patients that prefer to make monthly payments for their dental services. (Available upon approval)**

We offer: **"Dental Layaway" as an option for paying for future dental services.**

Financial arrangements are required for comprehensive treatment plans exceeding $800.00

- Finance Charges of 1.5% of remaining balance, with a minimum of $2.00 per month, will be added to all accounts that have aged beyond 60 days from the date services were provided.
- We reserve the right to charge and collect fees for broken appointments and appointments that are cancelled without 48 hour advance notice. Appointments are reserved exclusively for you; please respect all appointments in order to avoid fees associated with changes.
- We reserve the right to charge and collect a fee of $50 for any check returned to us for non-payment or NSF.
- We reserve the right to charge and collect all fees associated with using a collection agency to recover charges accrued on all accounts.

I have read and understand this financial agreement. I understand all above policies, and agree to enter into firm payment agreements for all services rendered on myself or my minor child.

Today's Date:

Print Name of Patient:

Signature of Patient or Guarantor