# FINANCIAL AGREEMENT
# FOR COSSICH FAMILY DENTISTRY

**At Cossich Family Dentistry we are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you wile minimizing our administrative costs.**

**All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relation ship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Cossich Family Dentistry is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you are responsible and you will be expected to pay the balance in full.**

**As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization of the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.**

**Your estimated copayment for treatment, which is the maount not covered by your insurance, is due at the time treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Cossich Family Dentistry accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.**

**Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month. (18% annually)**

**Additionally, our practice reserves the right to charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice. Patients with a history of missing appointments will be charged 30% of the treatment fee at time of scheduling as a deposit, which will be applied to the fee if the appointment is kept, but forfeited if appointment is not kept.**

**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**