LEXINGTON SMILE STUDIO

FINANCIAL AGREEMENT

Thank you for choosing Lexington Smile Studio as your dental practice. Our primary mission is to deliver the highest quality and most comprehensive dental care available. In order to serve you better please adhere and be advised of our policy.

DENTAL INSURANCE IN-NETWORK:

If you have dental Insurance that we are In-Network with: Your deductible and **estimated** co-payment will be collected at the time that the service is rendered. You may also receive a statement for any remaining account balance after insurance has processed. **Patient Initials:** _____

DENTAL INSURANCE OUT-OF-NETWORK:

In order to provide and continue to maintain our high standard of quality dental care, we are unable to participate with any dental insurance contracts due to the limitations imposed by insurance coverage. As a convenience to our patients we will gladly work with any Out of Network Insurance Carriers who **allows** treatment rendered by an Out of Network Providers. In order to maximize your benefits we will bill your insurance directly for reimbursement of your treatment and will collect your deductibles and **estimated** co-payments at the time of service. We will also follow up with insurance claims processing, however if we do not receive payment from your Insurance carrier within 60 days, you will be responsible for payment of your treatment fees. **Patient Initials:** _____

PRE-TREATMENT

Pre-determination and insurance benefit confirmations are available to you upon request in order to help determine what your financial responsibility is in conjunction to what your insurance should pay.

Patient Initials: _____

PAYMENT:

Payment is due in full at the time that service is rendered, unless prior arrangement has been made. We reserve the right to apply **a $25.00** monthly billing fee for any balance over 30 days. For your convenience we accept the following forms of payment: Master Card, VISA, Discover, Check and Cash. **Patient Initials:** _____

CANCELLATION POLICY: (fee may apply)

We would greatly appreciate 48 hour notice from any patient (or patient representative) should they need to reschedule or cancel an appointment. We do understand that occasionally circumstances arise that may keep you from attending your dental appointment. We reserve the right to apply a cancellation fee if this policy is not respected. If not given adequate notice a fee of **$50.00** may be applied for Hygiene cleaning appointments and a fee of **$50.00** per hour for Dental procedure cancellations. **Patient Initials:** _____

RADIOGRAPHS:

Original radiographs are the property of Lexington Smile Studios. If you wish to obtain a copy, we require 5 to 7 business days. **Patient Initials:** _____

I have read and agree to the above policy.

Patient Name: **DATE:**

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PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE