Financial Agreement

Payments: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and Amex. Returned checks are subject to a $40.00 insufficient fund fee per occurrence. Balances older than 90 days will be referred to a collection agency. You will be responsible for a 25% collection fee, interest in the amount of 18%, court costs, attorney fees, as allowed by law.

Broken/Rescheduled Appointments: Our office reserves the right to charge $50 per half hour for broken appointments and appointments rescheduled without 2 business days advance notice. We make every attempt to remind patients of their appointments but ultimately it is the patients' responsibility to keep their appointments.

Minors: Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-paid to a credit card or other payment arrangements have been made.

X-Ray/Records Release: I give permission to Potomac Dental Centre to release my records to specialist upon my or their request.

Assignment of Benefits: All charges you incur are your responsibility regardless of your insurance coverage. We provide an estimate for all procedures; however, we cannot guarantee your insurance will provide coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. As a courtesy to you we will process your insurance claims.

Authorization: I authorize the use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Potomac Dental Centre to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Potomac Dental Centre. I permit a copy of this authorization to be used in place of the original. I give Potomac Dental Centre, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Patient Name (printed):_____ Relationship to Patient:_____

Patient/Guardian Signature (SEAL):_____Date:_____