Financial Agreement for the office of Robert Miracle, DMD, PC

Last Name: First Name: Birthdate:

Date:

Thank you for allowing us to improve your dental health. It is our goal to provide the highest quality care to you and your family. We welcome any questions you may have regarding our services or payment policies. The best dental services are based on a mutual understanding between the provider and the patient.

* I will be prepared to pay any co-pay, deductible, non-covered service, or product fee at the time of my visit. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

* This office accepts cash, check, debit cards, Visa, Mastercard, Discover, and American Express. In addition, 12 months interest free financing through CareCredit is available with prior approval (arrangements must be made prior to receiving services).

* My dental insurance is a contract between me, my employer, and my insurance carrier. I will inform this office of any changes to my insurance since they are not a party to that contract. Estimates of treatment cost may change unexpectedly due to factors uncontrollable by this office.

* This office will attempt to understand my insurance benefits, but any charges incurred are my responsibility whether my insurance pays as expected or not. If insurance does not pay within 90 days, any balance remaining is my responsibility. I will pay a finance charge of 1.5% per month (18%APR) for any balance over 90 days old. If sent to collections, I will pay any related fees or court costs. Unpaid balances will be grounds for office dismissal for me and my immediate family.

* Every effort will be made to provide me with an accurate treatment plan. I understand unforeseen clinical circumstances can occur that can increase the cost of that visit.

* I authorize and request my insurance company to pay directly to this office insurance benefits otherwise payable to me. I authorize this office to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

* I will pay a fee for any appointments broken without 24 hours notice.

* In the case of divorced parents, the parent accompanying the underage child to the appointment is responsible for any balance incurred for that visit.

* If I have two insurance carriers, I will pay any cost of treatment not covered by my primary carrier. Any payment made by my secondary carrier will be sent to me.

* I will provide this office proof of insurance coverage and a valid drivers license/ID.

SIGNATURE of patient (parent or guardian if under 18 years of age)