Financial Terms and Agreement

Please read the following terms and sign at the bottom to indicate your acceptance of our office financial terms and policies. Thank you.

1. Payment is due at the time services are rendered.
2. We accept the following forms of payment: Cash, Personal Check, Visa, Mastercard, Discover/Novus. We also offer an extended payment plan with prior credit approval.
3. UCR (Usual and Customary Rates) Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. ***Insurance estimates are just that, estimates only. You are responsible for any amounts remaining after insurance pays.***
4. Minor Patients The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard/Discover, or payment by cash or check at time of service has been verified.
5. **An appointment is a reservation.** When you make an appointment, that time is not given to anyone else. Without adequate notice of your inability to keep your appointment, we are not able to give that time to anyone else in need of dental care and that valuable time is lost. We **do** reserve the right to charge for missed appointments or cancellations without at least 24 hours notice. A message left on our answering service on Friday does not constitute 24 hours notice of cancellation for a Monday appointment since the office is closed on Friday.
6. If you have dental benefits, please indicate your preferred method of payment for the services you receive in our office:

   _____I will pay for the services I receive on the day of my appointment and submit the claim for for reimbursement myself. I would like Dr. Zoch's staff to provide me with a completed claim form.

   _____I would like to assign benefits to Dr. Zoch. I understand that I will be expected to pay my estimated share (co-payment) on the day services are provided. I also understand that ANY amount that is not covered/paid by my insurance company is MY responsibility. My signature will be kept on file for all claims submitted on my behalf.

***For patients choosing to assign benefits**: By accepting assignment of benefits, the doctor is agreeing to delayed payment for services provided for up to 45 days or until a check is received from the insurance company. Since the patient is ultimately responsible for ALL fees incurred regardless of the level of reimbursement by their insurance company, accepting assignment is equivalent to extending credit to the insured/guarantor of the account. **Therefore, we require a guarantee of the balance assigned in the form of a credit card.**

Signature on File for Assignment of Benefits

I authorize release of any information relating to the claims Dr. Fred F Zoch will submit on my behalf for the dental services rendered in his office. I understand that I am responsible for all costs of dental treatment.

_____

Signed (Patient or Parent of a minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to Fred F Zoch DDS.

_____

Signed (Insured Person) Date

Please circle your choice of credit card for account guarantee: Mastercard Visa Discover Dental Credit Card

_____

Name as it appears on card (Please Print)

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __/__ __

Account Number

I authorize Dr. Fred F Zoch and his staff to keep my signature on file and to charge my credit card for any claim not paid by my insurance company within 45 days of the day the claim was sent or for any balance remaining on a claim after insurance payment has been received.

_____

Signature of cardholder Date

FOR ALL PATIENTS: I understand and agree to the terms outlined in this Financial Agreement. I agree to be responsible for all costs of my dental treatment.

_____

Signature of Patient. If a minor, signature of patient's parent or guardian. Date

Whom may we thank for referring you to our office? _____

Newspaper Advertisement_____ Magnet Letter_____ Phone Book(Describe)_____ Other_____