BENDER DENTAL GROUP
OFFICE AND FINANCIAL AGREEMENTS

We view our patient relationship with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health along with providing each patient the highest quality of dental care. The following is a statement of the Bender Dental Group Office and Financial Agreements. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

DENTAL INSURANCE

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us.

There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not being shared with us. Therefore, it is impossible for us to know exactly what your policy covers.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit. _____ (initial)

PAYMENT OPTIONS

Your options include Cash, Check, Mastercard, Visa, American Express and Discover. We are pleased to offer you the option of a No Interest Payment Plan through CareCredit. Anyone of our Admin Team members would be happy to assist you in completing this application form or can tell you how to fill out the application in the privacy of your own home. _____ (initial)

ADDITIONAL CHARGES

A fee of $25.00 will be charged on all returned checks. _____ (initial)

DELINQUENT ACCOUNTS

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. Any accounts turned over to collections will be assessed a collection fee of 30%. _____ (initial)

REGARDING CHANGES TO YOUR RESERVED APPOINTMENTS

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two business days notice. All changes in your scheduled appointment must be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ (initial)

I have read, understand and agree to the Office and Financial Agreements

_____ _____ _____

Patient Signature Date Child's Name

(PARENT/GUARANTOR signature if Patient is a MINOR)