



FINANCIAL AGREEMENT

Thank you for choosing Augusta Children's Dental Center as your child's pediatric dental care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered part of your child's treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered. This includes but is not limited to; dental exams, restorative procedures, x-rays, preventative procedures, dental appliances, and any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation **24 hours** in advance, you may be charged \$50.00/per child. Please help us service you better by keeping scheduled appointments. SEE DETAILED OFFICE POLICY

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether your insurance company pays their portion or not.

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, we will file claims for you.

ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES Are due at the time of service unless other arrangements are made with the office manager. Please indicate below the form of payment you wish to choose.

☐ Check or Cash (exact amount only)

☐ Visa

☐ MasterCard

☐ Discover

A monthly payment plan may be available for your convenience. Unpaid balances over 30 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the parent/guardian will be responsible for late payment fees and payment of collections up to 50%, attorney's fees, and court costs associated with the recovery of the monies due on the account. The parties agree that in the event of a dispute over any payment or fee due to Dr. Obebe by the undersigned, the Circuit Court of Richmond County shall have exclusive jurisdiction and venue for any litigation filed by either party.

By signing this form, I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature: _____

Date: _____

Print Name: _____