

OFFICE FINANCIAL POLICY

Thank you for choosing Next Level Dental as your care provider. Our office is committed to successful care and treatment of our clients. Please be aware that payment is considered part of your dental/massage treatment. We require that you read and sign this agreement prior to any dental/massage treatment.

1. Full payment is due at time of services
2. This office accepts Cash, Checks, MasterCard, Visa, Discover and Third Party Financing.

Past Due Accounts

After 45 days, unpaid accounts balances will be turned over to a collection agency unless prior arrangements have been made.

Checks

There will be a \$40.00 charge for all returned checks.

Minor Patients

When treatment is planned for minor clients the accompanying adult or parent (guardian) is responsible for full payment. We will not treat an unaccompanied minor in a non-emergency situation unless charges have been pre-authorized to an approved payment plan.

Broken and/or Missed Appointments

Unless canceled within 24-48 hours, Next Level Dental reserves the right to charge a minimum of \$20 and a maximum not to exceed \$100 per hour of appointment time reserved for any appointment not kept by the client. Also, if a client is more than 15 minute late there may be a need to reschedule. This is to keep other clients from waiting. After two (2) broken or missed appointment, the office reserves the right to discontinue elective treatment.

Insurance

We may accept assignment of insurance benefits from your insurance carrier. To properly file your claims we need all necessary information. After verifying coverage with your carrier, benefits will be calculated according to your treatment plan. All co-payments are due at the time of treatment. Any unpaid claims are your responsibility. Your insurance policy is a contract between you and your carrier. We are not a party to that contract. If your carrier does not pay within 45 days of treatment, your balance is automatically due and payable immediately by you.

I have read and agree to the above office Financial Policy. I have selected and agree with the above designated financial agreement. I accept financial responsibility for the procedures to be performed. I also understand that if I default on payment and can not resolve it with *Next Level Dental*, I will also be charged billing charges that will be greater than or equal to any court cost, attorney's fees, collection agency fees, and /or any other costs associated with collecting any incurred debt. A copy of this signed agreement has been provided to me.

Signature of Patient, Parent or Guardian

Date

Witness

Date