Alegria Dental Group
Financial Agreement

- I understand and accept that I am responsible for all payments whether the treatment is covered by insurance or not.
- I understand that my insurance contract is between the insurance company, my employer and me. Any efforts to collect payment from the insurance company will be handled as a courtesy by the dental office.
- I understand that insurance coverage costs quoted to me are **ESTIMATES** of what my insurance company may pay.
- I understand that it is my responsibility to inform the office of any changes in my dental coverage.
- I understand that it is my responsibility to inform the office if I have had treatment at another facility prior to coming to this office.
- I am aware that delinquent accounts may be turned over to collections if payment arrangements are not made and I am responsible for any costs incurred.
- I understand my insurance coverage that has been explained to me.
- I understand that all co-payments/payments are due on **the date of service.**
- Payments are to be made only in the form of cash, checks, money order, VISA or MasterCard
- I acknowledge that appointments are confirmed in advance as a courtesy, and that failure to show for my appointment without giving adequate notice will result in a $75 charge to my account.

I have read, understand and accept the 10 financial agreement terms as listed above.

Date **Signature of Insured/Guardian**

CHECK RETURN FEE

I understand that if I write a check to Alegria Dental Group for payment of treatment or services rendered and the **check is returned for insufficient funds**, I am still responsible for the payment due (which must be made in the form of cash, money order or credit card) as well as an **additional $25.00 check return fee.**

Date **Signature of Insured/Guardian**