Financial Policy.

Financial Agreement Between Prime Endodontics and Our Valued Patient

Welcome to our office. We will do our best to make your Endodontic therapy as pleasant and comfortable as possible, while promising you the highest quality treatment attainable. The final cost of your treatment will be determined by the complexity of your individual treatment and the tooth being treated. Not all teeth are created equal, and fees vary from tooth to tooth depending on their complexity. There can be additional fees for procedures such as retreatment, post removal, perforation repair, root resorption, and extra canals.

Prime Endodontics Responsibility
It is important to us that we provide you the finest care and service. We take this responsibility very seriously. We want the handling of your account, from the start through final payments, to be perceived as an extension of the excellent dental care we provide you and your family.

Patient's Responsibility
It is your responsibility to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

Requirements
We deliver the finest care at the most reasonable cost to our patients; therefore, **payment is due in full prior to treatment on the day of service.**

Missed Appointment Fee or Cancellation Under 24 hours

- $100: We have reserved that time especially for you. Short notice or no-show prevents other patients who would have wanted that time.

Forms of Payment:

- Credit Cards: Visa, MasterCard, American Express, Discover
- Cash
- Personal Check
- Extended Payment Plans With Credit Approval at Care Credit: carecredit.com, 800-677-0718

Regarding Insurance
As a service to our patients, we will file and take assignment of your insurance benefits. We will carefully estimate your personal investment for your dental care and make every effort to maximize your dental benefits. **This is an estimate only.** We cannot make any guarantees as to your insurance coverage. It is impossible to determine what the actual benefit for any service will be. **ALL deductibles, co-pays, unpaid insurance balances are the responsibility of the**

patient / responsible party and are due no more than 60 days from the date of service. Please review the Dental Insurance Disclaimer.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the Financial Agreement. I understand, accept, and agree to this Financial Agreement.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name of Patient or Responsible Party