HALLS
FAMILY DENTISTRY

Financial Statement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Agreement, which we require you to read prior to treatment.

All patients must complete our Registration and Medical/Dental history form before seeing the providers.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER, AMEX AND CARE CREDIT**

Regarding Insurance:
We will gladly estimate your deductible, your portion of treatment costs and bill your insurance company for your treatment, all at no extra cost to you. We do require that you pay your portion of the treatment fee (Co-Pay and deductible) at the time of service. We will bill your insurance company if we are provided with your insurance information and a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please read and know your own insurance policy. We are more than happy to assist you in billing your primary dental benefits provider, however, **if your insurance company has not paid within 45 days, you are responsible for the balance in full, and all insurance inquiries and follow-ups become your responsibility. The balance is your responsibility whether or not your insurance company deems your treatment to be covered benefit. If payment is not made as agreed, patient shall be responsible for any reasonable attorney fees, costs of collection and court costs incurred in efforts to enforce this agreement.**

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates.

PATIENTS WITHOUT INSURANCE
Patients without dental insurance are responsible for payment in full when treatment is received unless financial arrangements have been made prior to appointment.

FINANCIAL ARRANGEMENTS
In the event a short-term financial arrangement is necessary, payment options will be discussed on an individual basis.

Thank you for understanding our financial agreement. Please let us know if you have any questions or concerns.
I hereby authorize and direct payment of dental insurance benefits to Halls Family Dentistry, PLLC.
I understand and agree to this financial statement.

Signature Date