Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Summit Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2-business day prior to my scheduled appointment time (see Broken Appointment Policy for details.) **For appointments where major procedures are to be performed and are 90 minutes or more in length I may be required to put down a $200 non-refundable reservation fee. If I fail to give 48 hours' notification to cancel my appointment, this reservation fee will be forfeited (exceptions may be made based on circumstances). If I am seen for my appointment on its regularly scheduled time or if I provide sufficient notice of cancellation or to reschedule this fee will be applied towards my out-of-pocket copayment.**

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than two hundred and fifty dollars ($250) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Insurance:
I the undersigned, have insurance with _____, and assign directly to Summit Family Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

I have read and understood the patient agreement and financial policy above.

Date: _____ Signature: _____