

575 Fallbrook BLVD #107
Lincoln, NE 68521
(402) 467-0007



Office Financial Agreement

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover, or American Express.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your employer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring all required insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

We reserve the right to charge and collect fees for broken appointments. Appointments that are cancelled or broken without 24-hours advanced notice will incur a charge of \$50.00. Appointments are reserved exclusively for you.

Returned Check Fee of \$25.00 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment. We also have outside 0% financing available through Care Credit.

I have read and understand the financial agreement.

Printed name

Signature

Date

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

I understand the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient exam.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he, or she, is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his/her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X: _____ Date: _____
Signature of patient, or responsible party

Relationship to patient: _____

Referral Information:

Whom may we thank for referring you to our practice? _____