Laura Comeau, DDS
FAMILY, RESTORATIVE & COSMETIC DENTISTRY

FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to treatment date.
2) Cash, check, or Visa/MasterCard

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

X-Rays: If you have current X-rays from a previous dentist it is your responsibility to bring those to your appointment. If you do not notify us that you have current films/digital X-rays we will take new ones. Insurance companies have limitations on how often they will pay for X-rays. Therefore, it is important that you let us know if you have had recent ones taken.

Missed Appointments: Your good dental health is our main objective. Therefore, it is extremely important for you to keep all of your scheduled appointments. We understand that emergency situations do arise that may require you to change an appointment. As a courtesy to other patients and our office we ask for as much advance notice as possible. If any appointment is failed or canceled without 24 hours notice a fee of $40.00 will be charged.

I _____ realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past-due accounts will be subject to a charge of 3% interest per month. I am responsible for all collection costs incurred by the dental office and a fee of $30.00 on any returned check. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

Signature of Patient and/or Legal Guardian_____**Date**_____