# Edeen Family Dentistry

**806 Center Ave West**

**Dilworth, MN 56529**

## FINANCIAL ARRANGEMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, **we require payment at the time of treatment**. We ask that you read and sign this statement prior to any treatment. **YOUR CO-PAY & DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT.** We accept cash, checks, Visa & Mastercard. For extensive treatment plans, we offer extended payment plan with Care Credit Financing.

## REGARDING INSURANCE

We will gladly file dental claims for treatment you receive at our office. However, we are not party to any insurance programs or contracts. "Insurance" is a contracted agreement between you and your insurance company. The balance is **YOUR** responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage. If after 45 day we have not received payment from your insurance company, you will be billed for the balance.

## MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least **24 hours** in advance if you cannot keep your scheduled appointment. Our office reserves the right to charge the fee for a normal office visit for any missed appointments without notification.

## FINANCE CHARGES

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. Additionally, if my account reaches 90 days, a monthly administrative fee of $5.00 will be added to my outstanding balance until the balance is paid in full**. I understand that if my account reaches collection status and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Edeen Family Dentistry must take additional steps to collect my account, I will pay ALL costs of collection, including court costs and attorney's fees incurred by Edeen Family Dentistry.**

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Date: ____________ Signature: _______________________________________________

Phone:___________