BLUEBONNET DENTAL
FINANCIAL AGREEMENT

We appreciate you choosing our office for you and your family's dental care. At BLUEBONNET DENTAL, we value our relationship with you and your family and would like to offer the following as our payment policy regarding your insurance:

- You will be responsible for paying your deductible and co-payments in full at the time of service. **You are responsible for paying all charges not covered by your insurance company**, including all fees considered above your insurance company's usual and customary fee schedule. **Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased and provided by your employer, not the fees of BLUEBONNET DENTAL.**

- We will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will check your benefits and file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company. **If we do not receive payment from your insurance company within 60 days after submission of a claim, for ANY REASON, you will be expected to pay for all dental services rendered in full.** In the event of duplicate payments, your account will be reimbursed.

- Please be aware that **writing a "hot check," i.e. a check that you know will not clear the bank is a felony** and will be promptly filed at the courthouse by our office without any notification to you.

- We will make an effort to collect any unpaid balances from you for 60 days. After such time, a service charge of 1.5% per month (18% per annum) on any unpaid balances will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. **After 90 days, all outstanding accounts will be transferred to Lazarus Financial, a debt collection agency. Any and all collection charges will apply to the outstanding account.**

- Please note that parents/guardians bringing their child to the office will be expected to pay for all procedures rendered on the day of service.

I have read and understand the payment policies for this office:

_____ _____

Patient/Parent/Guardian PRINTED Patient/Parent/Guardian SIGNATURE

_____ _____

PATIENT NAME (If patient is child/ward) DATE