Watson Dental Care

Patient Financial Agreement

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.

2. I understand that it is solely my responsibility to confirm which treatments or procedures and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, annual or life time maximums)

3. I understand that as a courtesy Watson Dental Care will attempt to verify my insurance coverage from information that I provide. I am required to pay my portion in full, at or before treatment is rendered. (The estimated portion of any treatment that will not be covered by the insurance).

4. I understand that insurance claims will be filed if I provide Watson Dental Care with my social security and insurance identification numbers. If I choose not to provide Watson Dental care with this information, I understand I must pay in full for all services rendered. It is Watson Dental Care's policy to require SSN numbers and government-issued picture identification (driver's license or ID card) for record keeping and identification purposes.

5. I understand that although I pay my estimated balance on the date of service, the insurance estimate may differ from what my insurance carrier actually pays, If this happens I am aware I will receive a statement for the balance due and it is payable upon receipt.

6. I understand that all account balances over 30 days will incur and interest charge unless proper arrangements are made. We do not enjoy sending patients to collections and will try to make financial arrangements on overdue accounts.

7. I understand I will be charged $35.00 for any returned check.

8. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework, and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill/statement for a balance due.

I have thoroughly read, understand and agree to the above terms and conditions.

_____ _____

Printed Name Date

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Signature (or Authorized Guardian)

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If authorized guardian, relationship to patient