CHAUVIN & CHAUVIN, D.D.S., P.A.

FINANCIAL AGREEMENT

Patient Name: ____ Birthdate: _______________

We are committed to providing you with the best possible dental care. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining health service. Our fees reflect our professional commitment to excellence.

A. Payment in full is due at the time of service.

B. For patients with insurance, we will accept payment directly from the insurance company, **but require that the deductible and non-covered fees be paid at each visit.**

C. We are partnered with Care Credit and offer interest free extended payment plans. To apply go to www.carecredit.com or you can fill out an application in our office.

D. We also accept Check, Cash, Money Order, Visa, Master Card and American Express

Important Information Regarding Your Insurance

1. Your dental benefit program is a contract between you, your employer, and the insurance company. **This office files your insurance as a courtesy to you.**

2. Not **all** dental services are a covered benefit in all contracts. **It is your responsibility to know your benefits.**

3. You (not the insurance company) are responsible to our office for all of our fees for services rendered to you.

4. An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and **NOT A GUARANTEE OF PAYMENT**.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

Signature of Patient or Responsible Party___________________________________ Date___________