FINANCIAL POLICY AND AGREEMENT

The goal of North University Dental Associates is to make sure you receive the highest quality dental care and services. One step is to make certain that our financial policy is clear and understood by you.

Insurance

We will bill your insurance carrier as a courtesy to you. Please note that not all services are covered benefits in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. We recommend you become familiar with your insurance coverage and limitations.

Payment Options

- Payment in Full
  - A 5% professional courtesy is given to patients that do not have insurance when paying in full at the time of services. Payment by cash or check is necessary to receive the discount.
  - For all other payments we accept cash, check, and all major credit cards.

- Interest Free Financing through Care Credit
  - Please inquire for more information

Patient Responsibility

I acknowledge my responsibility for payment of the services received from North University Dental Associates in accordance with their regular fees and terms. I understand my responsibility is not modified by whether my insurance pays for all, part, or none of the charges. Additionally, I understand my account may be turned over to a third party for collection should I fail to pay for services provided.

Cancellation Policy

We respectfully request 48 hours notice for any scheduling changes. If we do not receive the requested notice, you may be charged for missed appointments, or dismissed as a patient. _____

(PATIENT INITIALS)

Assignment and Release

I authorize payment to be made directly to North University Dental Associates by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance carrier.

Again, thank you for choosing us as your dental care provider. We appreciate your confidence in us and look forward to helping you with your dental needs and desires.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

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PATIENT NAME (PLEASE PRINT)