Patient Financial Responsibility and Payment Options Agreement

Patient Name: _____ Date of Birth: _____

Thank you for choosing our office for your dental care. Please review and acknowledge our financial policies below.

Insurance Disclaimer

- Our office is happy to assist you in filing insurance claims as a Courtesy to our patients.
- Please note: **Insurance coverage is not guaranteed.**
    - Payment is determined only after the claim is reviewed by your insurance provider.
- If your insurance provider denies the claim or leaves a balance after processing, **you are responsible for the remaining balance.**

Payment Options

We offer several convenient ways to pay for your treatment:

1. **Cash/Check/Zelle** (QR Code will be provided in-office)
2. **Credit Cards/debit card** (Merchant *device has an additional processing fee)*
3. **CareCredit/ Sunbit / Cherry**

Patient Acknowledgment

By signing below, I understand and agree to the following:

- I am financially responsible for all charges incurred during my treatment, including any balance remaining after insurance payment or denial.
- I am aware of and accept the payment options available, including the credit card processing fee if applicable.
- I understand it is my responsibility to ensure timely payment of my account.
- If you have any questions about payment methods or assistance with financing, please let us know.

Patient Signature: _____ Date: _____

Responsible Party (if different): _____