BURKE DENTAL, PLLC

FINANCIAL AGREEMENT

ONE AGREEMENT IS GOOD FOR EACH ACCOUNT AND IS VALID UNTIL YOU
REQUEST AN UPDATED FINANCIAL AGREEMENT
PAYMENT ARRANGEMENTS ARE REQUIRED AT THE TIME OF YOUR VISIT

We now offer the following payment options: (Please chose one by initialing your choice)

_____ **PAYMENT AT TIME OF SERVICE**
(We accept Cash, Check, Debit Card, MasterCard, Visa, and Discover)
Entire fee is due the day of treatment (special arrangements may be made for some cases over $1,000)

_____ **INSURANCE** (IN NETWORK-certain plans offered by Delta Dental and United Concordia)
All other insurance companies are considered OUT OF NETWORK
Office will submit claims for you to insurance and estimate your co-payment at the time of service. **The estimated co-payment is due at the time of service.** After insurance pays its portion, **any remaining balance will be your responsibility and will be billed directly to you and will be due upon receipt**.

_____ **INSURANCE** (OUT OF NETWORK)
Please choose between the following two options:
_____Patient must pay in full at time of service and we will provide you with insurance forms to submit for direct reimbursement from insurance company.
_____Office will submit claims in full to your insurance company. **The estimated co-payment will be due at the time of service.** After insurance pays its portion, **any remaining balance will be your responsibility and will be billed directly to you and will be due upon receipt**.

Your agreement with your insurance company is between you and your insurance company. Any assistance by the doctor and/or staff in filing of insurance papers or confirmation of insurance payments is strictly given as a courtesy and implies no responsibility on their part for follow-up confirmation. If the insurance company does not remit payment within 60 days after the date of service, we will bill you with the remaining balance due and payable upon receipt from you. We are happy to file necessary forms to insure that you receive full benefits of your policy, but we make no guarantee of payments or any estimated coverage.

EXTENDED PAYMENT PLAN is always available for amounts over $1,000 if credit is approved beforehand.
This option allows you to pay Care Credit® up to 1 year, interest-free. Please see the front desk for an application if you are interested. Application must be approved BEFORE treatment is started.

INSURANCE INFORMATION

Policy Holder's Name_____ DOB_____ ID#_____
Policy Holder's Employer_____ Insurance Company Name_____
Insurance Company Address_____ Group #_____

FEES & PAYMENTS

Please give at least **24 hours notice** if you are unable to keep your appointment, otherwise you will be billed for services scheduled. **48 hours notice** is required for all evening (scheduled to begin 5:00pm or later) appointments.
The parent that accompanies a child is responsible for their visit.
A monthly finance charge of 1.5% will be applied to all accounts overdue more than 30 days.
A monthly billing charge of $10 will be applied to all accounts overdue more than 60 days.
All accounts that are overdue more than 90 days are subject to be turned over to a collection agency. In the event that this account is placed in the hands of a collection agency, interest will accumulate in the amount of 1.5% per month from the day the services were rendered, as well as attorney and collection fees, court costs, and filing fees.

This signature on file is my authorization to release any information to the insurance company to process my claim. I hereby authorize payment of my group insurance benefits to the dentist if any claims were filed by the dentist. I hereby certify that I have fully read and understand the above and agree with and accept all terms and conditions.

_____
Print Your Name Here

_____ _____
Signature Date

For office use only:
Account #_____
Name_____