FINANCIAL AGREEMENT

Insurance

Beaches Endodontics files insurance claims as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service, but this amount may be subject to adjustment when the claim(s) are adjudicated by the insurance company. In addition, you may have an annual limitation for the amount of dental services that can be reimbursed by your insurance company each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. You are responsible for monitoring the amount of your remaining benefits for any annual benefit period. While we do our best to provide accurate information to you, please do not rely upon any information provided by Beaches Endodontics regarding your remaining benefit in any such benefit period.

_____ please initial INSURANCE ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage, and authorize Beaches Endodontics to submit any and all claims for benefits on my behalf. I assign directly to Dr. Robert T. Radel all insurance benefits for any services provided to me. I authorize Beaches Endodontics to release to any insurance company or other entity responsible for paying such benefits any information necessary for the filing of claims or the determination of eligibility or benefits for services.

_____ please initial If the insurance company pays me instead of Beaches Endodontics, I become responsible for the total account balance and payment would be expected immediately.

_____ please initial **I am always responsible for any charges that are not covered or paid for by my insurance. I agree to pay for all charges not covered by a third party payor.**

_____ please initial **ESTIMATE: Before treatment is started, Beaches Endodontics will provide me with the best estimate of what my portion of the overall payment for services will be. I hereby acknowledge that this is ONLY AN ESTIMATE and may not necessarily be the EXACT amount that I can expect to pay for treatment received or services rendered.**

Delinquent Payments/Unpaid Balances

After 60 days, any unpaid balances will be assessed a late penalty of 10% which will accrue every 60 days until the balance is paid. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $35.00.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge $100 for missed appointments.

I give consent for invoices to be mailed to the mailing address provided, and also to be e-mailed to the following e-mail: _____

By signing below you acknowledge that you have read the above in its entirety and that you are financially responsible for any unpaid balance for services provided.

_____ _____

Patient (or Parent/Guardian) Signature Date

_____

Patient (or Parent/Guardian) Printed Name

Beaches Endodontics
Robert T. Radel, DMD, MS