Bruce Nelson DDS
LASER & MICROSCOPE ENHANCED DENTISTRY

FINANCIAL AGREEMENT

Our office understands the value of insurance benefits, and we are happy to assist you in filing the necessary forms. This done as a courtesy to our patients and there is no guarantee of coverage. The insurance carriers base the amount of benefits on a fee schedule that they arbitrarily develop. For this reason,you may receive less of a benefit than we estimate for you. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. Once you r insurance carrier has paid, you will be responsible for any difference upon receipt of our statement. If for any reason your insurance carrier has not paid within 60 days from the date of treatment, you are responsible for the entire balance at that time. In addition, the unpaid balance may be subject to 18.0% annual percentage rate (APR) interest charge.

In the event of default, legal interest on the indebtedness, collection costs (which could be as high as an additional 5O%) and related attorney's fee could also be added.

CHILDREN OF DIVORCED/SEPARATED PARENTS

Unless you give us a signed, notarized court order to keep on file, the parent who brings the child in for their visit will be considered ultimately financially responsible for that visit. Anyone else who might bring your child in for a visit also assumes this responsibility. We entrust you to tell us whom the bill needs to go to for any remaining balance after insurance pays. Please keep in touch with the office whenever fina ncial responsibility changes for your child. We will work with you as much as possible. I have been given a copy of the financial policy and agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice, at wh ich time t he practice will give me verbal/written notification of such amendments.

CANCELLATION AGREEMENT

Our office requires a 48 hour notice for any cancellation. This is so we can allocate other patients in need of urgent dental care. A $54.00 fee will be charged if less than 48 hours notice is given. This fee is entir ely the patient's responsibility, and is not covered by your insurance.

PAYMENT

Payments are expected as services are rendered. Payment and charges made at the time services are estimates until your insurance carriers and the provider have made the appropriate adjustments to your account. Insurance companies may deny your claim, at which time you will be responsible for the who le balance.

We accept the following: MasterCard, Visa, American Express, Discover, Cash,Check, Money order, or Care Credit.

I understand my financial obligation as outlined above. I am aware that any balance outstanding after sixty (60) days is my responsibility. The treatment plan has been explained to me and I have agreed to the terms as listed.

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Patient/Responsible Party Signature Date

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Witness for Bruce L. Nelson DDS,PC. Date