FEE ESTIMATE AND PAYMENT AGREEMENT

-Payment is due at the time of service.
-Total treatment fees and the amount due on the day of the appointment can vary due to occasional changes in treatment during the procedure. Please bear in mind that any estimates made prior to treatment or by phone are subject to change. Your final payment amount will be determined once all treatment is completed.
-If you are covered by insurance, please be aware that most insurance plans do not cover the entire cost of your dental treatment. Only a percentage (50-80%) of what the insurance companies are willing to pay for a particular procedure is paid. What the insurance companies are willing to pay is frequently much lower than the actual cost of treatment.
-As a courtesy, we will file your insurance for you at no charge, but please remember that your insurance contract is between you and your insurance carrier. **Payment for treatment is your responsibility. You are responsible for the entire charged amount regardless of your insurance benefits.**
-Once insurance benefits have been received the ENTIRE REMAINING BALANCE is due **IN FULL** within 30 days upon receipt of statement; otherwise the account will be turned over to our professional collection agency.
-NSF checks are subject to a $25.00 service charge.
-Credit cards and debit cards are subject to a 4% processing fee.

_____**(Read and Initial)** Commercial dental insurance is verified during the days leading up to your consult appointment. From the time of verification, to the time a claim is submitted to your insurance company can sometimes be weeks, even months. This is the nature of some treatment cases. If your insurance coverage changes during this interim time period, for instance, coverage is terminated or annual benefits are depleted, your estimated portion can change. You are still responsible for whatever charges your insurance denies or does not cover. If payment is not received within 30 days of completion of the case, the guarantor on the account will be turned over to collections.

I hereby authorize payment of the dental insurance benefits, otherwise payable to me, directly to Joshua D. Beaver, DDS, and LLC, if applicable.
I understand that any remaining balance on my account must be paid within 30 days of the date of the initial billing statement. I will be responsible for any accrued interest, attorney fees, and/or other collection costs that may be imposed to collect any amount due on my account. To the extent permitted under applicable law, I authorize release of information relating to my account.

_____ _____
Patient/Responsible Party Signature **Date**