**PATIENT FINANCIAL AND INSURANCE BENEFITS AGREEMENT**
**FORTHE OFFICE OF JACKSON DENTAL ASSOCIATES**

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate excellent service to you while minimizing our administrative costs.

We require you to sign this agreement and/or any necessary documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and facilitate payment to our office. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. All charges you incur are your responsibility regardless your of insurance coverage. We Must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to the contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full. Our office will not enter into a dispute with your insurance company over any claim, although we will Provide the necessary documentation your insurance company requests to sort out any questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any dispute over payments made or not made by your insurance
company. Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time we provide the service to you. The co-payment is only an estimate and may be found to be insufficient after review by your insurance company.
Our office accepts cash, personal checks, American Express, MasterCard, and Visa. Additional financing is available through Care Credit upon approval.

Returned checks and balances older then 30 days maybe subject to collection fees and finance charges at The rate of 1.5% per month(18%annually)

**I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.**

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SIGNATURE/DATE OF PATIENT/RESPONSIBLE PARTY