BENCHMARK FAMILY DENTISTRY

FINANCIAL AGREEMENT

Office of Dr. Troy A. Clovis & Dr. Sarah S. Hunt

I agree to pay Dr. Clovis and/or Dr. Hunt the amount for all professional treatment and services provided to me, my family, or other persons indicated. Payment must be made in full at the time services are rendered. Accepted methods of payment are:

CASH

CHECK

CREDIT CARD (MasterCard, Visa, Discover or American Express)

CARE CREDIT (Revolving Credit Card which can be used for dental.)

ASSIGNMENT OF INSURANCE BENEFITS

As a courtesy to their patients, Dr. Clovis and Dr. Hunt will submit most insurance claims and will allow 60 days for an insurance company to make payment. After 60 days, I become responsible for the remaining balance on my account. I understand that I must pay my co-payment, deductible, etc., and should insurance benefits provide less coverage than expected, I remain liable for all amounts not paid by my insurance.

Please understand that insurance coverage is an agreement between you and the insurance company. It is not easy for an office to become familiar with the details of every dental plan it encounters. It is the responsibility of the patient, not the dental office, to know what is covered and what it excluded from his or her dental plan.

In the event that I do not pay at the time of service, the unpaid balance will be subject to a monthly finance charge of 1.75% (annual percentage rate of 21%).

In the event of non-payment resulting in the referral of my account to an attorney or collection agency, I agree to pay all legal costs and charges including but not limited to reasonable attorney fees, court costs, disbursements and collection-agency charges incurred for the collection of my account.

DATE: _____ **RESPONSIBLE PARTY:** _____

PATIENT: _____

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