Drs. Morrow, Lai, & Kitterman
Financial Agreement

We value your business and want to meet the dental needs of your children. Our hope is that this Financial Agreement will clarify any questions regarding our expectations of payment on your account.

Our Payment Agreement is as follows:

1. **IF YOU ARE SELF PAY** – Payment in full is due at the time services are rendered.

2. **IF YOU HAVE DENTAL INSURANCE** – The patient portion is due in full at the time services are rendered. **A dental insurance plan is a contract between <u>you and your insurance company</u>. We encourage you to be familiar with your benefits.** Because we have no control over this contract, we are not held responsible for what they do not cover. With the information given us by your insurance company, we will **<u>ESTIMATE</u>** the amount we believe to be your portion. However, the insurance company may pay differently than we anticipate. **You are responsible for what your insurance does not pay.**

3. **AS A COURTESY** – We will file your insurance and will send you a statement explaining any outstanding balance that may remain. If we do not receive a payment from you within 90 days, your account will be turned over to the Collection Agency that handles our past due accounts.

4. Any unpaid "Returned" checks will be handled by the District Attorney.

5. We request a 48 hour cancellation notice on all appointments. We will request a $50.00 rescheduling deposit if you are unable to give this notice.

I understand my financial obligation and any balance over 45 days old is my responsibility. Furthermore, I understand that in order to avoid a $50.00 rescheduling deposit, I must give a 48 hour cancellation notice.

Dr. Mark Morrow, Dr. April Lai, & Dr. Kerry Kitterman

I have read and understood the Financial Agreement.

_____ _____

Name (sign) Name (print)

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Date