



## **FINANCIAL AGREEMENT ACKNOWLEDGEMENT**

We are committed to providing you with the best possible dental care. By offering our patients only the best materials, dental lab and dental treatment, our fees reflect our professional commitment. We are happy to assist you in billing your insurance and obtaining your maximum benefits. In order to achieve these goals: please acknowledge our financial policy.

### **Dental Insurance:**

Our office will file your claims with most dental insurance carriers to assist you in receiving your benefits. **We will be happy to give you an estimate of what your insurance carrier may pay but please note that it is an estimate.** It is the patient's or guardian's responsibility to know their dental benefits. Co-payment and/or your estimated portion of any charge are due on the same day of service. We submit all claims to the insurance companies for you, if for some reason your claim does not get paid or services are not covered, you are responsible for the amount that is due.

Initial: \_\_\_\_\_

### **Texas Medicaid/CHIP:**

I understand that, in the opinion of Texas Kids Dental Care, The Services or items that I have requested to be provided to me on \_\_\_\_\_ may not be covered under Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the service or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically for my care.

Initial: \_\_\_\_\_

### **Care Credit**

Care Credit is an independent financing agency not affiliated with this office. Care Credit offers 3, 6, and 12 months "same as cash" as well as other payment plans (with approved credit). This program is available whether or not you have dental insurance. There are no enrollment fees, annual fees, or down payment required. For your convenience Care Credit applications are available. Approval may be obtained within 5-10 minutes.

### **Collections**

If it becomes necessary to turn this account over for collections, I promise to pay all attorneys' fees, court cost, and all other costs of collection of my account. We will also add a fee to your balance that is 30% of the total balance due once the account is turned over to the collection agency.

Initial: \_\_\_\_\_

### **Other Forms of Payment**

We Accept Visa, MasterCard, Check, Cash, Care Credit, and Springstone.

- A \$25.00 Fee will be charged for all returned checks.

The undersigned has read the above and agrees to pay for all services rendered. This form was signed in the El Paso County and all services are performed in the El Paso County.

X \_\_\_\_\_  
Patients Signature or Guardian (if patient is a minor)

\_\_\_\_\_  
Date