THE DENTAL CENTRE

OFFICE OF DR. JACK FAN, PLLC
4301 W. WILLIAM CANNON, BLDG.B, STE. 240
AUSTIN, TX 78749

Dear Patient:

Thank you for choosing us as your dental care provider. The following is a statement of our Financial Agreement, which we want you to fully understand prior to your treatment.

FINANCIAL AGREEMENT

Payment of your bill is considered a part of your treatment plan and is due on the day services are provided. As a courtesy, we file insurance claims for you if you have dental insurance. This means you have to agree to assignment of benefits so your insurance can pay us for services provided to you.

Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and your portion of your treatment cost as accurately as possible. **All deductibles and your estimated portion of payments are due at the time of service.**

Please be aware that your insurance company will not guarantee coverage of your treatment over the phone. We will not know the exact amount they will cover until they pay the claim. Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the portion of your treatment that they may cover. The insurance company is required to respond and settle all claims within 45 days of receiving the claim. If you insurance company does not pay your claim within the 45 days, you will be responsible for the unpaid portion of your account in full. Once a payment is received on your claim from the insurance company, we will send a statement to you for any remaining balance.

Our office requires a **24 hour cancellation notice policy**. If we do not receive notice of cancellation, or if you no show your appointment, there will be a $50.00 - $100.00 fee.

I have read and understand the above financial agreement. By signing below, I acknowledge responsibility to adhere to the terms as written above.

____________________________ ____________________________

Print Patient's Name **Responsible Party's name** (if different)

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Signature of Patient or Responsible Party **Date**