Searcy Dental Associates, P.A.
Office Policies and Financial Agreement

It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of fees for services rendered. Prior to treatment, you will be advised of the approximate cost. For convenience, we accept *Cash, Check, Visa, MasterCard, American Express, Discover & Care Credit.* All emergency dental services or any dental service performed without previous financial arrangements with the financial staff must be paid for at the time of service.

Patients Not Covered By Dental Insurance: Payment in full is expected when services are rendered.

Patients Covered By Dental Insurance: We will be happy to complete the necessary forms for your dental claims as a courtesy to you. You are responsible for providing us with the correct insurance information, including name of employer, group number, subscriber's social security number or ID number, date of birth and a toll free number to contact the insurance carrier.

Your insurance coverage is a contract between you, your employer and your insurance company. **You are responsible** for the entire bill regardless of your insurance coverage. We are a third party providing dental services to you and your family. This office requires that you be responsible for your co-payment and deductible at the time of service. We will allow 60 days for your insurance carrier to reimburse us for services provided. If your insurance carrier fails to issue reimbursement within this time frame, the outstanding balance will be your responsibility and a statement will be sent.

Time: Your time, as well as the doctor's and staff of Searcy Dental Associates, is very valuable. We reserve the time for your dental appointments, ***just for you.*** We request that IF the need arises and you have to reschedule an appointment, please provided us with a minimum of **48 hour notice. Failure to notify us in a timely manner or not keeping your scheduled appointment may assess a $45.00 fee.**

In consideration for the professional services rendered to me, I agree to pay for those services in full. I agree that a $10.00 late fee per month can be added to any account balance that is over 90 days. In the event that my account is turned over to a collection agency, I agree that a collection fee of $150.00 can be added to my account. In addition, I agree to pay any court costs and attorney fees which may be associated with my account. I grant my permission for you to telephone me at home or work to discuss matters related to this form.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICY AGREEMENT.
Patient/Guardian

Signature_____ ***Date***_____