AGAVE DENTAL
Smile Esthetics and Wellness

At Agave Dental we are committed to providing you with the best possible care. We want you to have a **great** dental experience! Our professional relationship is based on mutual trust and understanding. If, at any time, you have any questions or concerns, we are here and happy to help. We feel that open communication is the best way to avoid any confusion or misunderstanding.

*****Please read (and initial) each of the following statements regarding your insurance and our office financial policy.**

**Insurance:**

_____ **We must emphasize, as dental care providers, that your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract and we do not determine if services are covered or non-covered.** We will bill your insurance company as a courtesy to you- please understand that all charges are your responsibility from the day services are rendered- regardless of any pending insurance. If we are in network with your insurance company that means we are required to use their fee schedule for any covered procedures.

_____ We try to estimate your co-insurance as closely as possible with the information that we have. After the insurance company processes your claim there may be a balance or a credit. We will send you a statement if there is a balance due or return your credit to the original form of payment used.

_____ If your insurance company has not processed your claim within 60 days, you may be billed for the remaining amount due and then be reimbursed if, and/or when, the insurance company makes their final determination of your claim.

**Forms of Payment:**

_____ We take cash, check, Visa, Master Card, Discover, American Express and Care Credit. (We also have an in-office payment plan option – please ask anyone at the front desk for more details).

_____ All co-payments are due at the time services are rendered. Any payment plan/arrangements must be made prior to having services performed.

_____ Returned checks are subject to an additional $40.00 fee

**Missed Appointments:**

_____ We have reserved time in the schedule specifically for you. We do require 48 hours notice to change any appointment you have reserved. If less than 48 hours notice is given - there will be a charge in the amount of $50.00 per hour. Please help us provide you with the best service by keeping your reserved appointment times.

**I understand and agree to the above Financial Policy.**

Signature of patient/guardian: _____ Date: _____