FINANCIAL POLICY

Thank you for choosing Lifeway Dental of Boca as your dental home. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible, which requires an understanding of your responsibilities.

Please take a moment to read the following, sign, and date the bottom of this form.

FINANCIAL AGREEMENT

I understand that payment is due at the time services are rendered. No refunds. If treatment requires multiple appointments, payment is due prior to the completion of your treatment. If other financial arrangements are made, I further agree that payment is due upon receipt of invoice/ statement. Any discounts for services are only good when the balance is paid in full at the time of services. Discounts will be reversed if not paid on the day of service.

Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started.

INSURANCE BENEFITS

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary and secondary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 90 days may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility. If you do not pay your estimated co-pay at service, or the remaining balance after insurance benefits are collected, we will no longer accept your insurance as payment, and you will be responsible to pay in full, file your own claims and wait for reimbursement.

You are responsible to know if a procedure is a covered benefit, whether you have benefits remaining for the year, and what your deductible or co-pay percentages will be for your treatment. The terms of your benefits are decided by your employer or insurance company, not our dental office. If a claim is rejected, your insurance carrier requests more information, or delays paying your claim, we will take action on your behalf, in an effort to secure payment, however this in no way implies that we are responsible for your insurance benefits. We will take action with your insurance carrier on your behalf for up to 90 days after which time the remainder of the unpaid balance will be due by you.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to be made directly to Nick Cicortas DMD LLC (DBA Lifeway Dental of Boca) of all benefits that may be due and payable under insurance coverage for the named patient. I authorize utilization of this application or copies thereof for the purposes of processing claims and effecting payments.

INITIALS _____

PATIENT BALANCES

Patient balances that go unpaid for 120 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

In the event a legal suite is necessary to enforce payment of this account, I agree to pay such collection fees, attorney's fees and court costs as may be deemed reasonable. Patient / guarantor waves venue jurisdiction and submits itself to the jurisdiction and venue of State Courts of Palm Beach County, Florida.

Patients with past due balances will be required to pay the balance in full before receiving further treatment, unless other arrangements have been made. A service charge of 1.5% per month (18% per annum) may be charged on all balances more than 90 days past due.

There will be a minimum fee of $50 for any checks returned as Non-Sufficient Funds (NSF).

I understand and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

CANCELLATION POLICY

We begin preparing for your visit 2 days before your arrival and reserve a dedicated time with the doctor and/or hygienist. Therefore, we kindly ask for a 2 day notice if you need to change your appointment time.

Patients are asked to **confirm their appointments at least 24 hours in advance** by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be given to another patient in need. If a 24-hour notice is not given, a cancellation fee of a minimum **$50** will apply.

Patients that cancel without sufficient notice more than once within a twelve (12) month period will be required to pay a refundable deposit of $50 to hold an appointment time. The deposit will be applied to payment due or refunded, on the day of appointment after the completion of the appointment.

Patient name: _____

Signature of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney : _____

Date :_____