Prime Dental Care -USA
Financial Policy and Agreement

The following statement is our financial policy which we require that you make an informed decision by reading, agreeing and signing prior to any examination or treatment.

APPOINTMENTS:
Our Policy require a notice of 48Hours for any missed, cancelled or rescheduled appointment.
Appointments missed, cancelled or rescheduled with less than 48 hours notice without a valid explanation will result in Short Notice Appointment Cancellation fee of $100 billed to your account.

INSURANCE:
Please remember your insurance policy is a contract between you (or your employer) and the insurance company. Prime Dental Care USA is not a party to that contract. As a courtesy to you, our office provides certain services, including insurance verifications, billing, pre-treatment estimates which requires tremendous time, efforts and cost to our facility.
It is physically impossible for us to have knowledge and keep track of every aspect of your insurance.
It is up to you to contact your insurance company and inquire as to what benefits you or your employer has purchased for you. If you have any questions concerning your Pretreatment estimates and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Pretreatment estimates are just estimates, final adjustments occur after insurance reimburse or denies payments; we will appeal any denial if possible for 1 time then you are responsible for the amount due**.**
Regardless of any insurance status, you are responsible for the services at our facility.

PAYMENT:
Copayments or Full PAYMENT is due before any service is rendered.
If insurance benefits apply, Pretreatment Estimate, CO-PAYMENTS and DEDUCTIBLES are due before any service, unless other arrangements are made.

***All balances 30 days and over are PAST DUE and subject to interest.**
***In the event, you or your insurance company fail to pay within 90 DAYS and it is necessary to employ outside collections efforts, you are responsible for costs for collection, including but not limited to court costs, attorney fees and collection agency fees.**

All parties agree that in event of a dispute over any balance due to PRIME DENTAL CARE USA by the undersigned, County courts (where office is located) shall have exclusive jurisdiction and venue for any litigation filed by either party.

*By signing, I understand and agree to the terms and conditions of this Financial Agreement.
Patient name or legal Guardian:_____
Signature: _____
Date:_____