

Lake Highlands Dental Financial Agreement

For Our Patients With Insurance, Please Select One Of The Following Options:

OUR OFFICE WILL FILE YOUR INSURANCE CLAIM FOR YOU. THIS IS A SPECIAL SERVICE WE PROVIDE FOR OUR PATIENTS TO HELP ELIMINATE SOME OF THE OFTEN-CONFUSING PAPERWORK ASSOCIATED WITH PROCESSING CLAIM FORMS.

OPTION 1

YOU CHOOSE TO PAY YOUR BALANCE IN FULL ON THE DATE OF SERVICE. WE WILL SUBMIT YOUR INSURANCE CLAIM FOR YOU WITH DIRECTIONS TO SEND THE REIMBURSEMENT DIRECTLY TO YOU.

OPTION 2

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. OUR OFFICE IS NOT A PARTY TO THAT CONTRACT. IF YOU PREFER WE WAIT FOR YOUR PAYMENT FROM YOUR INSURANCE COMPANY, WE REQUIRE A CREDIT CARD WITH AUTHORIZATION TO TRANSFER ANY BALANCE LEFT UNPAID BY YOUR INSURANCE COMPANY 30 DAYS AFTER THE DATE OF SERVICE.

Card Holders Name: _____

Visa

Master Card

Discover

American Express

Account # _____ Exp.Date _____

I have read Lake Highlands Dental Financial Agreement and have selected my form of payment

Signature: _____

For Our Patients Without Insurance

PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

FAILURE TO KEEP APPOINTMENTS AND/OR LATE FOR APPOINTMENTS

We realize that there can be unexpected circumstances to cause a failed appointment. However, we reserve the right to charge each patient for repeated failed appointments if we do not receive 48 hours notice to cancel your appointment, the charge may be as follows \$50.00 per reserved hour. We also have the right to reschedule your appointment if you are more than 15 minutes late. Please contact our office during normal business hours Monday-Thurs 7:00am to 5:00pm at 214-343-9280.

PATIENT OR GUARDIAN SIGNATURE

Date