CENTRAL TEXAS
DENTAL CARE

CTDC Financial Agreement

As a condition of your dental treatment in this office, ***financial arrangements must be made in advance.*** This practice depends upon reimbursement from the patient and the insurance company for costs incurred in their visit at the time of service. Therefore, the patient must consider their financial obligation prior to the visit.

All dental services including emergency services must be paid at the time services are rendered. We accept MasterCard, Visa, Discover, American Express and Care Credit. Please ask us for more details and options.

Patients who carry dental insurance must understand that this practice will do our best in preparing your insurance forms or ***assist in making collections from insurance companies*** and will credit any such collections to the patient's account. However, our dental practice cannot render services on the ***assumption*** that our charges will be paid at 100% by an insurance company. Also, if a claim is not paid within 30 days, the balance is your responsibility. To assist in filing your claim, please come to your appointment with all the necessary DENTAL insurance information. The benefits belong to you, and it is your responsibility to understand the benefits of your plan. ***We encourage you to contact your insurance prior to treatment.*** There is no guarantee of benefits from the insurance company until a claim is received and processed by the insurance company.

Patients must understand that the Proposed Treatment Plan fee estimate listed is just that, an **estimate**. Treatment plans developed in this practice are subject to change depending on the specific dental condition.

- *In consideration for the services rendered to me by the doctor, I agree to pay in full my estimated portion at the time of service (per the first paragraph). I also agree that I shall be responsible if a remaining balance exists once insurance has paid. I agree to pay all collections costs and attorney fees if a suit shall be instituted.*
- *If for any reason you request records or x-ray transfer, an administrative fee may be charged.*
- *Returned check fee is $35.00*
- *Proposed Treatment Plan fees quoted are honored for (3) months*
- *I grant permission to you and your staff, to telephone me at any time to discuss matters related in this form.*
- *I have read and fully understand the above conditions of treatment and agree to its content.*

*Please realize that we do file your insurance as a **courtesy** to you. Any questions/concerns regarding your claim is **your** responsibility to follow up on. We strive to provide you with timely and efficient service each time you visit our practice and in doing so your assistance is greatly appreciated.

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