**EM Dental Patient Financial and Cancellation Agreement**

**\*\*ALL ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE\*\***

**FOR OUR PATIENTS WITH DENTAL INSURANCE:**

We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

Your dental insurance is an agreement between you and your insurance company.

Most dental plans do not cover 100% of the cost of treatment All patient copayments and/or patient portions are only an estimate/never a guarantee of payment.

As part of your contract with your insurance company, you are responsible for all out of pocket portions/copayments and deductibles.

Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full.

**MISSED APPOINTMENTS OR SHORT NOTICE CANCELLATIONS:**

We understand that your plans and daily schedule can change. When they do, a 24hr notice is greatly appreciated when you need to reschedule your appointment. **A FEE OF $50** will be assessed to cancelations with less than 24hrs notice and no notice prior to appointment.

**GUARANTEE OF WORK:**

EM Dental guarantees its dental work for 12 months after the service has been completed, provide you have maintained 2 regularly scheduled preventative appointments annually.

**I have read, understand, and agree to all of the above. I have been given the opportunity to ask questions. If I have insurance, I hereby authorize my insurance company to pay my dental benefits directly to the doctor. I authorize EM dental to release any of my medical information to my insurance company as needed to process my insurance claim.**

**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**