Cooper Owens Financial Agreement

Payment: Payment is due at time services are rendered. We accept the following forms of payment: cash, check, Master card, Visa, American Express and Care Credit. You are more than welcome to leave your credit card on file to be run for outstanding balances. Without that on file, outstanding balances will be subject to $5 billing/finance charges. In the event that your account goes to collection we will add a $100 collection fee.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental plan. Benefits and payments received are based on the terms of the contract negotiated. We are happy to help our patients with dental benefit plans to understand their coverage, but we cannot guarantee the accuracy of information received from the insurance company or any changes regarding the contract. It is increasingly difficult for us to get insurance companies to pay. If your claim has not been paid after 30 days you will be billed for the amount.

If we are a contracted provider with your plan, you are responsible for the approved fee as determined by your plan. We are required to collect the patient's estimate portion (deductible, co-insurance, copay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with your dental plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out of network providers. If your plan allows reimbursement for services, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance you are responsible, and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan, even if that amount is different than our estimated patient portion of the bill. If you choose not to "assign benefits" to our practice, you are responsible for filing the claim and obtaining reimbursement and will be responsible for payment in full to our practice before, or at the time of service.

Authorizations: I authorize the team to perform any necessary dental services I may need and have consented to during diagnosis and treatment,discussions. I authorize release of information necessary to be made directly to Cooper Owens DDS for services rendered to me.

HIPPA: By signing below you understand that under HIPPA you have certain rights to privacy regarding your protected health information and have read the sign posted.

Signature of responsible party _____ Date _____

Print Name _____