Financial Agreement

Avalon Dentistry

Thank you for choosing Avalon Dentistry as your dental health care provider. We are committed to providing the highest quality dental care. To ensure clarity and avoid misunderstandings, we require all patients to review and agree to the following financial policies. Please understand that payment for dental services is considered an integral part of your treatment.

Before treatment is performed, we will discuss recommended treatment, estimated fees, and available financial options. This allows you to make informed decisions regarding your dental care. Please note that insurance benefits are determined by your employer and insurance carrier—not by your dentist.

Insurance Coverage

Patients with dental insurance should understand the following:

- Your dental insurance policy is a contract between you and your insurance company. Avalon Dentistry is not a party to this contract and has no control over plan limitations, exclusions, reimbursement methods, or benefit determinations.
- Some services may be classified by your insurance company as “not covered,” “denied,” or “over UCR.”
- As a courtesy, we will submit primary insurance claims on your behalf. This does **not** relieve you of responsibility for payment of your account.
- We do not guarantee payment from your insurance company and are not responsible for explaining plan limitations or benefits.
- You are responsible for payment of all services rendered to you and/or your dependents.
- If your insurance plan requires a referral or preauthorization, it is your responsibility to obtain it. Upon request, we will submit a pre-determination or preauthorization; however, all insurance estimates are **not guarantees of payment**.
- Your estimated co-payment, deductible, and any non-covered charges are due **in full on the day services are rendered**.

By signing this agreement, you authorize Avalon Dentistry to release necessary information—including diagnosis, treatment records, and examinations—to insurance companies, third-party payers, and other healthcare practitioners for purposes of treatment, payment, and healthcare operations.

Avalon Dentistry will submit **one appeal** for any denied insurance claim. If the appeal is unsuccessful, the remaining balance becomes the patient’s responsibility and must be paid promptly. Patients are responsible for contacting their insurance company directly with questions regarding coverage or payment.

PATIENT INITALS: _____

Patients Without Insurance

Patients without dental insurance are required to pay **the full fee for services rendered on the day of treatment**.

PATIENT INITALS: _____

Accepted Forms of Payment

We accept the following forms of payment: - Cash - Check - Visa, MasterCard, American Express, Discover - CareCredit

PATIENT INITALS: _____

Billing, Finance Charges & Collections

- Statements will be issued every **15 days** for any unpaid balance.
- A finance charge will be applied every 30 days to unpaid balances at a rate of **1.5% per month (18% per annum)**.
- Payment is due within **15 days** of the statement date.
- Accounts with balances unpaid after **90 days** may be referred to **Bonneville Collections Agency**.
- If an account is sent to collections, you agree to pay all associated costs, including:
    - A collection fee of **33.33%** of the balance
    - Accrued interest
    - Court costs
    - Reasonable attorney's fees

PATIENT INITALS: _____

Returned Checks

- A **$50.00** fee will be charged for any check returned by the bank.
- After a returned check, personal checks will no longer be accepted as a form of payment.

PATIENT INITALS: _____

HIPAA & Payment Authorization

In accordance with federal HIPAA regulations, we may use and disclose your protected health information as necessary to obtain payment for services. This includes billing, claims submission, collections, eligibility determinations, and coordination with insurance carriers or third parties.

PATIENT INITALS: _____

Effective Date & Acknowledgment

This Financial Agreement becomes effective upon signature and remains in effect for all current and future services rendered by Avalon Dentistry. By signing below, you acknowledge that you have read, understand, and agree to all terms and conditions contained in this agreement, including financial responsibility for all services provided.

PATIENT INITALS: _____

Patient Printed Name:

_____

Patient Name & Signature:

_____

Date:

_____