SERENE FAMILY DENTISTRY

Patient Care Cancellation and Financial Agreement

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by Serene Family dentistry and I understand that payment is due at the time of service unless prohibited by an existing contract between Serene Family Dentistry and the insurance company. For procedures that are billed to my insurance I understand that I become personally responsible for the charges in the event that my insurance company does not provide payment within 60 days.

I understand that all copayments are due at the time of service. I understand that my insurance company may not cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for I will endorse the check to Serene Family Dentistry within 5 business days of said payment. If my insurance company reimburses Serene Family Dentistry for services that I paid for at the time of services that I paid for at the time of service or prepaid I understand Serene Family Dentistry will reimburse these payment. In those instances in which an insurance company has made a co-insurance, deductibles, and non-covered services.

_____**I understand a $50 fee will be charge for appointments not cancelled within 24 hrs.**
Initial

_____**I understand I'm financially responsible if my insurance doesn't pay for the dental procedure performed**
Initial

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Name

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Signature Date