FINANCIAL AGREEMENT

For the purposes of this document, the "dental practice" is **Pure Dental**, 5321 East Mockingbird Lane, Space 210, Dallas, TX 75206. Phone: 214 -824 -7873

Our goal is that our patients understand their treatment needs, as well as its exclusive financial responsibility before starting treatment. It is our desire to make dental care affordable to all our patients. Please review the following policies and procedures:

PAYMENT POLICY: Payment is due at the time of the service. If you have dental insurance, your estimated co-payment plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

1. We accept cash, personal checks with proper identification, money orders, debit cards, Visa, MasterCard, Discover, American Express

2. If there is a balance and charges have been in the account for more than 90 days, you will have to pay the Dental Practice 18% finance charge per month on the outstanding balance until it is paid in full.

3. You will be responsible for any and all expenses incurred in the collection of the debt (i.e., collection costs, court fees and/or attorney fees)

4. Financing is available through Care Credit and Compassionate Care with prior approval.

5. A fee of $ 35 if applicable for any check returned by the bank.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1. You must provide us with an insurance card and/or all information necessary to verify your coverage and file your claim.

2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you; not with your insurance company.

3. You are responsible for paying our fees; not what your insurance company allows or considers "usual, customary and reasonable" (UCR), all of which vary from one company to another.

4. Although we can estimate your insurance benefits we are not responsible for their accuracy. Knowing the amount of your benefits, limitations, exclusions, waiting periods, etc. is entirely your own responsibility. Receiving our services implies the acceptance of responsibility to pay regardless of our estimate.

5. All charges not paid by your insurance company are your responsibility, regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits vary from one company to another. Rates for non-covered services, plus deductibles and co-payments are due at the time of treatment.

6. Treatment provided in another dental office during the current plan year may alter your co-payments due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum. Please call your insurance company if this applies to you.

7. There are many factors in determining patient responsibility in case of coordination of benefits between two insurance companies. We will provide you the most accurate information available to us, but we cannot guarantee what your out of pocket benefit will be.

8. Please understand that our responsibility is to provide treatment that best suits your needs, not to try to match your care to insurance plan limitations.

CANCELLED OR MISSED APPOINTMENTS: To cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $ 25.00 (fee based on consultation length and/or the number of missed appointments). Missed or cancelled appointments prevent others from receiving the dental care they deserve.

1. We reserve the right to terminate or suspend professional treatment of any patient when scheduled appointments are not kept.

I have read and understood this document in its entirety; outlining the office and financial policies of the dental practice and agree to these terms.

Patient Name / Guardian _____

Signature of Patient / Guardian_____ Date: _____