Modern Dentistry, PLLC
3409 Wisconsin Ave. NW
Washington, DC 20016

PATIENT FINANCIAL AGREEMENT

________________________________ ________________________________
Print Patient Name **Print Responsible Party Name**

Read the following statements and initial the line that best represents your insurance and/or financial responsibility.

________ I do not have an insurance carrier and understand payment is due in full at time of service.

________ I will file all insurance claims and paperwork myself (without any assistance from the doctor's staff). Payment is due in full at time of service.

________ I would like the doctor's staff to bill my insurance as a courtesy to me.

- I understand filing an insurance claim is not a guarantee of payment.
- I understand the estimated portion based on the insurance information obtained from my insurance carrier is due at the time of service.
- Once the insurance has processed my claim there may be a remaining balance on my account which is due at that time.
- Modern Dentistry, PLLC will verify my eligibility and benefits to the best of their abilities.
- Detailed information is not always available from the insurance carrier.

Insurance coverage is estimated. I, the patient, am responsible for all amounts not covered by my insurance carrier. Unpaid account balances after 90 days from the date of treatment will be charged a service charge of 18%.

Missed/Canceled Appointments

Missed or canceled appointments without a 24 hour noticed will be charged a $50 cancellation fee per appointment hour. Your appointment time is exclusively for you and no other patients are scheduled for that time. We cannot fill your spot without sufficient notice.

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Patient or Financially Responsible Adult Signature ***Date Authorized***