FINANCIAL AGREEMENT

Patients with Insurance

I understand that any expected payment from my insurance company is an estimate only and that I am responsible for any portion not covered by insurance. I further understand that my estimated portion must be paid in full on the day of the treatment. Any amount not covered by the insurance company is due and payable in full immediately upon notification by the insurer. It is my responsibility to verify my coverage. If payment is not completed as agreed and communication has not been made with the office, we will be forced to turn account over to a collection agency. Any/all collection charges shall be paid by me (the patient), and office shall not be held liable for any damage to patient credit rating.

Patients without insurance

I understand that payment is expected at time of service. I further understand that any portion not paid at this time is my responsibility. If payment is not completed as agreed and communication has not been made with the office, we will be forced to turn account over to a collection agency. All collection charges shall be paid by me (the patient), and office shall not be held liable for any damage to patient credit rating.

No Show fee

Effective October 1, 2019 any appointments not cancelled within 24 hours prior to appointment time will be subject to a $50 fee.

- ✔ Print Name: _____
- ✔ Patient's Signature: _____
- ✔ Date: _____

Logan B. Hall, DDS, PLLC