FINANCIAL AGREEMENT

Premier Dental Esthetics
301 W. Huntington Dr. Suite 217, Arcadia, CA 91007

The practice is committed to providing optimal treatment for our patients based on a diagnosis of what is in the best interest of their dental and overall health and well-being.

1. PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.
2. WE ACCEPT *CASH, CHECK, VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS & CARE CREDIT.*
3. APPOINTMENTS CANCELLED LESS THAN 48 BUSINESS HOURS ARE SUBJECT TO A BROKEN APPOINTMENT FEE.
4. WE WILL PREPARE & SUMIT CLAIMS FOR APPLICABLE PPO/DPO DENTAL INSURANCE.
5. NO SERVICE CAN BE SUBMITTED TO HMO/DMO INSURANCE PLANS, MEDICARE, DENTI-CAL, And OTHER SIMILAR PROGRAMS. MEDICAL INSURANCE MAY COVER CERTAIN PROCEDURES; WE WILL PROVIDE ASSISTANCE FOR YOU TO SUBMIY CLAMIS IF YOU HAVE A PPO MEDICAL INSURANCE PLAN.

Please be prepared to make payment at the time of your appointment. Any alternate arrangements must be made with the front desk prior to your appointment. An account is deemed delinquent if payment is not received in accordance with this policy or separate mutually agreed upon arrangement. Delinquent accounts are subject to a finance charge of 18% APR (regardless of insurance) and no further treatment can be scheduled until the balance is resolved. You agree to pay all legal expenses necessary for the collection of any debt.

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Checks are accepted with proper identification. There is a returned check fee of $35 and Alternate means of payment may be required for future charges. A Broken Appointment fee of $50 is applicable to any appointments not cancelled or rescheduled with a team member at least 48 hours prior to the appointment time.

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If you have a PPO/DPO Dental Insurance Plan, we will prepare and submit claims provided you complete the Insurance Agreement with valid information with the understanding that you are responsible for payment of services rendered. Your estimated patient portion is due at each visit. Once your insurance has made payment to our office (Assignment to Doctor), or 31 days from the date of submission, any remaining balance will be charged to your credit card on file.

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If you do not maintain a credit card on file, any remaining balance must be paid within30 days of the insurance payment, or 31 days from the date of submission, or you may forfeit your Assignment to Doctor Status in which case you will be asked to make payment in full when services are rendered and be reimbursed by your insurance company.

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If you have medical insurance, please read the back of this form, initial where appropriate, sign and date. HMO's, Medicare, and similar programs will not reimburse and cannot be billed for services rendered in this office. If you are covered by Medicare please check the box on the back of this form, read thoroughly, sign and date.

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Flexible Spending/Savings Accounts vary greatly. It is your responsibility to know the requirements of your plan request documentation in a timely manner and meet your deadlines. We can only run cards in your presence and reversals of charges cannot be handled by our office.

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By having services rendered you agree that you are ultimately responsible for all charges incurred. This agreement applies to any patient for whom you are the account guarantor and supersedes all prior agreements signed. In the event that financial responsibility changes, you understand that you remain financially responsible until a new agreement is signed and accepted by our office.

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A deposit of 25% the cost of the treatment will be requested when long (more that 90 minutes) appointments are made. This deposit will be a credit for the scheduled treatment. However, this deposit will be non-refundable when the appointment is broken with less that 48 hours prior to the scheduled appointment.

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There can be a $100 charge on broken dental hygiene visit and visits that are less that 90 minutes. If that is a charge of schedule, we would appreciate a 48hours notice or it will be considered a broken appointment.

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Patient Name (if other than Guarantor) Guarantor Name Social Security # Driver's License #

Signature of Account Guarantor_____ Date:_____

CREDIT CARD ON FILE:" I AUTHORIZE Premier Dental Esthetics, Dr. Peter Young's office to charge this credit card in accordance with the above agreement and the cost amount of treatment/s to be provided.

Credit Card: AmEx Visa Master Discover CC#_____SC _____ Exp Date:_____

Card Holder's Signature:_____ Date:_____