Financial Agreement

Alaska Center for Dentistry, PC
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Wasilla, AK 99645
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Financial Agreement and Authorization for Treatment

We wish to stress that the Financial Responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. **Your insurance policy is a contract between YOU and YOUR Insurance Company. We cannot guarantee payment of your claim.** If it is not paid, the insurance company should explain to you why it was rejected or downgraded in payment. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you.

We try our very best to get an estimated cost of your dental coverage but it is only that, an estimate. Every policy has different rules and limitations. We bill your insurance as a courtesy to you. If you would prefer to have no financial surprises, you can pay for services in full and we will bill your insurance for your direct reimbursement. Or you can also request a dental treatment preauthorization which takes about 30 days to receive from insurance.

Initials____________

If any overpayment is received it will be refunded to you. Should your account become 60 days past due, an interest charge can be applied to your account.

I hereby authorize the release of any dental or financial information necessary to process claims for services rendered.

In the event legal action should become necessary to collect an unpaid balance for dental services to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper.

I authorize treatment of the named patient and agree to pay all fees and charges for such treatment. I understand that payment is due at the time of service. I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balances on my account. **Initials_______**

I will be responsible for any scheduled appointments and will give 24 hours notice to cancel or reschedule any appointment, or I will be subject to a cancelation fee. **Initials__________**

Patient/Guardian Signature   Witness Signature

Date: _____________________