

Bridges & Buckner Dentistry by Design

Financial Agreement

I agree that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for charges not covered by insurance. I agree that in the event of a default in the terms of my agreement to pay my just and due obligation, I will be responsible for all costs associated with the collection of this debt including but not limited to: Collection Fees, Delinquency Charges, Late Fees and Legal Costs. **I agree that a \$75 charge will be made for missed appointments and appointments cancelled without a 24 hour notice.**

Assignment & Release of Insurance

I, the undersigned, have insurance and assign all benefits for services rendered to C. Todd Bridges, DDS/Nathan Buckner, DMD. I understand that my insurance policy is a contract between myself, my employer and my insurance company. I understand that the doctors are not a party to that contract and that I am financially responsible for all charges whether or not paid by insurance. I understand that not all services are covered and that some insurance companies arbitrarily select certain services that they will not cover. I understand that, as a courtesy, my insurance will be filed and that my estimated copay and any deductible is due at the time of service. I understand that if there is any remaining balance after the insurance has paid, a statement will be sent for payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

All patients must sign this agreement in order for services to be rendered.

Signature _____ Date _____