

Financial Agreement

1. INSURANCE FILING / PAYMENT

As a courtesy to our patients, we file dental insurance claims on their behalf. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. By signing this form, you agree to assign the payment of insurance benefits directly to Elmore Dental Associates; and authorize the release of any information related to processing of these claims. If the insurance company fails to pay the claim as requested, the patient is immediately liable to make those payments to us.

2. INSURANCE/ RESPONSIBLE PARTY INFORMATION

The following is for:  the patient  the person responsible for payment (**Circle one:** Spouse/Parent/etc)  
Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_  
Social Security Number (SSN): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ Married/Single/Child/Other (circle)  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_

Name of Primary Insurance Holder: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Insurance Plan Name: \_\_\_\_\_  
Insured Person's Date of Birth: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Insured Person's Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

3. APPOINTMENT CANCELLATION/RESCHEDULE POLICY

We care for you and your loved ones – so we pledge to:

1. Always be on time and minimize wait-times
2. Respect your schedule and provide most convenient appointment times

To help us achieve these goals and deliver a comfortable/homely experience – we allocate resources and time for each patient's appointment. **We are most satisfied when you leave our office very happy.** We understand that you may occasionally need to move or change your appointment with us, we request that you kindly provide us 24 hours' notice prior to your appointment time for any changes.

Our practice charges the following fees to help us keep our schedule current /available for emergency patients:

1. \$35 per missed appointment or failure to provide 24 hours' cancellation notice

I have completely read and understand the contents of this agreement and agree to comply with these payment policies.

\_\_\_\_\_  
Signature: (Patient/Parent/Guardian)

\_\_\_\_\_  
Date