Pure Dental Care 122 Courtyard Drive Hillsborough, NJ 08844 908.218.7999

PURE DENTAL CARE AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following statements are our office and financial policy, which we require that you read and sign prior to any treatment.

GENERAL: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance**. It is up to you to contact your insurance company and inquire as to what benefits are included in your policy. If you have any questions concerning the pre-treatment estimate and/or fees for service contact your dental insurance, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.** Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Consequently**, if a claim is denied by an insurer, the cost of treatment ultimately remains the patient's responsibility.**

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. Please indicate below the form of payment you wish to choose. We charge a $50 return check fee. Late fee of $10 will be added every 30 days for unpaid balance. Any balance left unpaid after 90 days without attempt at resolution will be considered for collection. A collection fee of $150 will be added to account if placed in collection.

( ) Check, Visa, MasterCard, Discover, Amex
( ) Cash, any cash payments of $500 or more qualify for a 5% discount.
( ) If you qualify, a monthly payment plan is available for your convenience (written agreement required).

APPOINTMENT CANCELLATION POLICY: When we make your appointment, we are reserving a room for your needs. We ask that if you must change an appointment, please give us at least 48 hours' notice (we need two full working days' notice to cancel without penalty).

A $75 charge will be made of failed or cancelled appointment without prior notification of 48 hours.

If you have unsubscribed yourself out of our software confirming system, you are responsible to remember your scheduled appointment. These fees are not covered by insurance and is therefore the sole responsibility of the patient. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely dental care. Any record requests please allow 2 working days.

PATIENT COMMUNICATION: Pure Dental Care may communicate with me electronically at the email address and/or mobile phone number provided. Patient must provide Pure Dental Care with any updates to address, phone number or email address.

MINORS ACCOMPANIED BY THE PARENT/ LEGAL GUARDIAN: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

XRAYS: Pure Dental Care we follow The American Dental Association (ADA), and the U.S. Food and Drug Administration (FDA), recommendations for dental radiographic. Dental treatment without proper radiographs is risky and considered practicing below the standard of care. If continued resistance occurs, the doctor may dismiss the patient from the practice.

HIPPA Policy: I have read and acknowledged the Health Insurance Portability and Accountability Act (HIPPA) that was presented to me. A copy of this form is available those that would like one.

I acknowledge I have received and agreed to Pure Dental Care's Payment & Financial Policies.

Signature: _____ Date: _____