EUGENE DENTAL
GROUP

Dr. Elizabeth A. Vivona
Dr. Sheeva Azimi

FINANCIAL AGREEMENT

INSURANCE BENEFITS, CO-PAYMENTS, GENERAL FINANCIAL OBLIGATIONS

We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. **All estimated co-payments are due on the day of service**. In the event that your insurance pays more than we anticipated, we will promptly send you a refund check in the amount of the credit you have on your account.

It is important to understand that the agreement regarding your dental benefits is between you, your insurance company, and your employer. Although we are willing to submit dental claims on your behalf as a courtesy service to you, we do not accept responsibility for the outcome of the transaction. By having our practice process your insurance forms, it does not eliminate your financial obligation.

Insurance payments are usually received within 30 business days from the time of billing. If your insurance company has not made payment to our practice within 30 days, we will ask you to pay the entire balance at that time and you will be responsible for seeking reimbursement from your insurance company

Our practice accepts cash, personal checks, Mastercard, American Express and Visa. Third party extended payment financing through Citi Health and Care Credit is also available upon request and approval.

Balances older than 30 days will be subjected to finance charges at the rate of 1.5% per month (18% annually). Returned checks will incur a fee of $35 in addition to the finance charges. **Delinquent accounts of 90 days may be subject to a $150 collection fee.**

PAYMENT PLAN ARRANGEMENTS

If a payment plan has been arranged with you, the payments must be made within 5 days of the monthly "due date". We will send you a reminder statement and if you fail to make a payment after that notification letter, you may be subject to further action.

CANCELATION POLICY

If you cancel, reschedule or fail to show up for an appointment without giving us at least 48 hours notice, you may be subject to a **"no-show" fee of $50.**

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT AND I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO EUGENE DENTAL GROUP.

_____Date_____
Signature of Patient or Responsible Party

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Print Name of Patient or Responsible Party