MAGNA DENTAL, PC
PATIENT FINANCIAL AGREEMENT

(REVISED 4-12-2017)

PATIENTS WITHOUT INSURANCE:
*PAY IN FULL AT EACH APPOINTMENT

PATIENTS WITH INSURANCE:
*NEW PATIENT-PAY IN FULL DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS).
*CURRENT PATIENTS PAY 30-50% DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS).
*BALANCES ARE REQUIRED TO BE PAID IN FULL WITHIN 60 DAYS OF SERVICE IRREGUARDLESS OF INSURANCE COVERAGE.
*WE SUBMIT CLAIMS ONLY AS A COURTESY FOR YOU. IT IS YOUR RESPONSIBILITY TO FOLLOW UP ON ALL UNPAID CLAIMS.
*PRE-ESTIMATES ARE NOT A GUARANTEE OF BENEFITS.

PATIENTS WITH DELTA INSURANCE:
*DEDUCTIBLE HAS TO BE PAID IN FULL
*YOU WILL BE RESONSIBLE FOR BALANCE IMMEDIATELY AFTER INSURANCE HAS PAID.

COLLECTION:
*ALL ACCOUNTS 60 DAYS PAST DUE (EXCEPT DELTA ACCOUNTS) WHICH INCLUDE BALANCE, INTEREST, OR ANY OTHER FEES, ETC. WILL BE SENT TO A COLLECTION AGENCY(IES) WITH A 1.5 % LATE FEE ADDED.
*ALL FURTHER QUESTIONS REGARDING YOUR ACCOUNT WILL BE ANSWERED BY THE COLLECTION AGENCY(IES).
*THE COLLECTION AGENCY WILL ADD TO YOUR BALANCE 30-50% AGENCY FEES, ATTORNEY COST, THIRD PARTY EXPENSES, COURT COST, SHERIFFS FEES, ALL DIRECT AND INDIRECT COST, ETC.

MISC.:
*THE PARENT/GUARDIAN/POA, ETC. THAT BRINGS A PATIENT IS THE ACCOUNT HOLDER FOR THAT PATIENT'S BILLING.
*ALL REFUND CHECKS CAN ONLY BE WRITTEN FOR THE ACCOUNT HOLDER.
*PARENTS/GUARDIANS/POA/ETC. WILL BE REQUIRED TO FILL OUT THE PAPERWORK AND BE HERE FOR THE INITIAL VISIT OF THE PATIENT THEY ARE BRINGING.
*BENNY CARDS/HEALTH SAVINGS/MEDICAL OR DENTAL CARE CREDIT CARDS/PREPAID CARDS: MAGNA DENTAL, PC IS NOT RESPONSIBLE FOR TRACKING, FOLLOWING, UNDERSTANDING AND IS NOT A PROVIDER, CONNECTED, AFFILIATED, OR UNDER CONTRACT. USING YOUR CARD IS TRULY A FORM OF PAYMENT FOR DENTAL SERVICES RENDERED. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE PERIMETERS, BENEFITS, AND LIMITATIONS, OF USING YOUR CARD. THE FINANCIAL POLICY OF MAGNA DENTAL, PC AS EXPLAINED ABOVE SUPERSEDES.

BY SIGNING THIS YOU HAVE READ, AGREE, AND FULLY UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

SIGNATURE OF PATIENT: _____
(OVER 18 YEARS OF AGE)

SIGNATURE OF PARENT/GUARDIAN
POA/CUSTODIAN: _____

DATE: _____