DENTAL ARTS OF CORINTH, PLLC
OFFICE PAYMENT POLICY AND AGREEMENT

We appreciate your selection of our office to serve your dental health needs. To avoid misunderstandings concerning payment of accounts, please note that Payment in Full is required for all dental treatment. We will be happy to file insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff proper information (Dental Insurance Card, Social Security Number, and Date of Birth of the person you are filing dental insurance under). **The estimated difference that the insurance does not pay is your responsibility and must be paid the day of each office visit.**

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, **Dental Arts of Corinth, PLLC**, only indirectly. Therefore, any controversy which might arise over your insurance companies handling of your claim is for you to resolve. Any discrepancy between the insurance companies allowance and your total indebtedness remains your responsibility. Any insurance claim that has not been paid within 45 days of treatment will be billed back to you. **We are a Provider for a limited number of PPO insurance policies.** Because of this, if you are covered under any plan other than PPO policies we participate in, you will be responsible for patient portion noted on your Insurance Explanation of Benefits. These stipulations also apply to **ALL CHIPS, MS CAN** and **Medicaid** participants where applicable.

All account balances over 90 days old will be charged a finance charge of $5.00 per month on the balance. Any account that has not been paid within 45 days after service will be referred to a collection agency or a collection attorney. **A returned check fee of $40.00 will be charged for all returned checks.**

( ) I have dental insurance and will pay my portion today. I understand that my portion today may be an estimate and I agree to pay the final balance to **Dental Arts of Corinth, PLLC** upon receipt of a statement.

( ) I agree to pay in full for services received at each visit. We accept cash, check and most major credit cards, Citi Health, and Care Credit.

( ) Financing information available upon request.

I hereby assign, transfer, and set over to **Dental Arts of Corinth, PLLC** all rights, title and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of any dental information needed to determine those benefits.

It is also agreed by you, the patient or guardian of a minor patient, that in order for us to service your account or to collect monies you may owe, **Dental Arts of Corinth, PLLC**, and/or our agents may contact you by the telephone number(s) given by you and associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provided for us to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

This agreement affects all services and charges present and future; and this authorization shall remain valid until written notice is given by me revoking said authorization.

I authorize the verification of my employment by this office or in the event my account becomes delinquent, by any Collection Agency or Law Firm to which my account is referred.

I/We have read this disclosure and agree that **Dental Arts of Corinth, PLLC**, its employees and/or agents may contact me/us as described above.

I/We understand I am financially responsible for all charges for my dependents or myself whether or not they are covered by insurance. In the unlikely event this account is submitted for collections, I the undersigned agree to pay any and all collection costs and reasonable attorney's fees.

I/We the undersigned, agree to all of the terms stated above and agree to pay accordingly.

Guarantor Signature: _____ Date: _____

Co-Guarantor Signature: _____ Date: _____