MICHAEL CHAPMAN DDS
Family and Cosmetic Dentistry
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# Patient Financial and Insurance Agreement

Welcome to our office. We are honored that you have chosen us as your dental health care provider.

Quality dental care is a financial investment. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

For patients with dental insurance we are happy to work with you to help you understand and maximize your benefit. Insurance companies and coverage can vary. Your contract for insurance exists between you and your insurance carrier. Regardless of insurance coverage, you are responsible for your account with our office.

Payment is due at the time services are rendered unless prior arrangements have been made.

**Payment Options:**

- Cash, Check, Mastercard®, Visa®, American Express®, and Discover Card®.
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card.

**Please note:**

- If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
- We may provide an estimate of your liability prior to any appointments for services that cost more than $400 so that you will be financially prepared.
- In the event of a default of payment or after 90 days, a service charge of 1.5 percent per month or 18 percent annually will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.
- A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without a 2 business day notice.
- A fee of $20 will be assessed for returned checks.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask – we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

[1]Subject to credit approval