Union Hills Family Dental
822 E. Union Hills Dr. Suite D-6
Phoenix, AZ 85024

_____ **Financial Agreement**

Payment in full, for all charges is required at the time of visit, unless prior arrangements have been made.

_____ **Financial Responsibility**

I further agree to pay all finance charges, collection costs, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

_____ **Insurance Filing**

The patient is ultimately responsible for their account, not the insurance company. We do file dental claims as a courtesy to our patients. We can only ESTIMATE your insurance benefits. In the event your insurance company does not pay as much as expected, you will be billed for the balance.

_____ **Assignment of Insurance Benefits**

I/We hereby assign benefits directly to Union Hills Family Dental. I/We hereby authorize the release of any information relating to any claim. I/We understand we are financially responsible for any charges not paid by this assignment.

_____ **Delinquent Accounts/Collection Proceedings**

You are responsible for your account balance after 45 days. If the account goes over 45 days we will be assigning these accounts to a collection agency for assistance. This may be an automatic assignment unless prior arrangements have been approved by Dr. Rubio-Ellis or the Financial Coordinator.

_____ **Failed Appointments**

Failed appointments (less than 48 hours) are a significant contributor to rising health care costs. Individuals who fail to show for a scheduled appointment will be charged a $25.00 fee.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

Signature: ______________________________ Date: ____________________