SCOTTSDALE
DENTAL SOLUTIONS
DENTAL IMPLANT CENTER

**Financial Responsibility Form**

Thank you for trusting your dental needs with Scottsdale Dental Solutions. To provide you with the best possible dental experience and to ensure we meet your expectations, please read and feel free to ask any questions before signing our financial responsibility form.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

You may feel that dental treatment is out of your reach. Please don't. We offer a variety of convenient payment options to make treatment available and affordable. We continue our commitment to you by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, and most credit cards. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. A $35 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

We will communicate all recommended treatment options and associated fees prior to the start of treatment. 20% of the patient responsibility will be expected when scheduling your treatment appointments, with the remaining treatment balance due at the time of service. A 5% treatment discount is available for balances paid in full in advance for cash pay patients. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist in receiving the dental benefits. We require that any applicable deductibles and estimated patient portions be paid at the time treatment is rendered. Knowing your dental insurance benefits is your responsibility; however, we will do our best to provide you with as much information as possible. Insurance plans vary from covered services to benefits paid and even yearly maximums. We will make every effort to provide as much information regarding your coverage as we are able, however, as the dental care provider our relationship is with you and not the insurance company. We will also do our very best to estimate your portion for dental services, but remember it is only an ESTIMATE. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

I have read the above financial policy and acknowledge and agree it is my responsibility to pay the balance for services incurred. I understand that I am responsible for any additional patient balances due once insurance benefits have been received. I acknowledge that I am responsible for any charges refused or discontinued by my insurance company. Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them during the agreed upon time.

Printed Name _____ Date _____

Signed _____

Witnessed _____