866 Seven Hills Drive St 102
Henderson, NV 89052
Phone: (702) 805-8185
Email: info@firstbitedental.com

FINANCIAL AGREEMENT

Dental Insurance can be a big help to most families by helping to cover some of the fees associated with dental treatment. However, dental insurance plans are usually very different from most medical plans. We hope the following information will give you a better understanding of dental insurance.

1. There are literally hundreds of dental insurance plans, and each one is different. It is not possible for us to know what procedures your insurance does and does not pay, when we recommend treatment for your child. We do not plan or recommend our treatment based upon what an insurance company will pay. We recommend treatment based upon what we feel is in your child's best interest.
2. We can provide an estimate of what your insurance may pay, and what your co-pay may be, but it is only an **ESTIMATE**. Sometimes proposed treatment can change which may increase or decrease the amount due from insurance and/or you. Reimbursement depends on the yearly maximum amount balance of your insurance plan. The yearly maximum is usually from $750-$2,000. It is your responsibility to know this amount and what you have already used. You are liable for any unpaid balance that your insurance has not paid.
3. You, the parent or guardian, not the insurance companies, are ultimately financially responsible for the payment of charges for treatment rendered. If an insurance company denies payment for a treatment or procedure you are responsible for the denied amount of the claim.
4. You are responsible for giving us accurate insurance information. When information is inaccurate it may delay treatment, authorization, or payment, which could lead to you having more out-of-pocket expense.

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Date

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Patient Name: _____ Date of Birth: _____

_____ For my convenience, this office may release my information to my insurance company and receive payment directly from them.

_____ I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

_____ If sent to collections, I agree to pay all related fees and court cost.

_____ Every effort will be made to help me with insurance, but if they DO NOT pay as expected, I will still be responsible.

_____ I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

_____ I will pay a fee for appointments broken without 48 hours' notice.

_____Treatment plans may change, and I will be responsible for the work that has been completed.

_____ _____
Parent or Guardian Signature Date