Patient Financial Agreement Form

Welcome to Morfas Family Dentistry. Our professional staff is committed to your treatment being successful. The following is a statement of our Financial Policy, which we ask you to read and sign prior to receiving treatment.

Authorization

I hereby authorize the release of pertinent medical information to my insurance carriers. I am aware that dental coverage varies, and while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the doctors and staff of Morfas Family Dentistry. If I have insurance I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered necessary by my insurance company. Payments are due on date of service.

Missed Appointment Charge

I understand and agree that if I fail to keep my scheduled appointment and I do not give at least 24-hour notice of cancellation, I will be charged for the scheduled time. **The missed appointment charge will be $50.00.**

Returned Checks

I understand that if the bank returns a check for NSF there is a $50.00 processing fee that will be added to my account.

Attorney Fees

In the event that I fail to pay the balance of my account to Morfas Family Dentistry within sixty (60) days of the date of service my account will be turned over to collection. In the event that it is necessary to turn my account over to collection, I will also be responsible for any and all costs of collection including attorney fees, interest charges, court costs, and filing fees.

Authorization and Release

I have read and fully understand the Patient Financial Agreement as outlined above.

I understand that this Authorization shall apply to all services provided to me, my dependents, spouse, or any other person for which I have assumed responsibility by signing below, from the date forward until it has been revoked in writing.

_____ _____ _____

Patient's Printed Name Date Patient's Signature

Patient Email Address_____