

Canton Dental Group

Financial Agreement

Payment is due at the time of service. As a courtesy to you, our office will verify your dental benefits, however, it is ultimately your responsibility to know what your insurance covers. We will submit the charges to your insurance company. Insurance is designed to cover a port of our fees only. **You co-pay, which is an estimate, is collected at each appointment. I authorize my insurance company to pay Canton Dental Group directly.**

_____ *Initial Here*

Cancellation and Failure to Arrive

We understand that circumstances do arise that can keep you from your dental appointment. We require 48 hours notice to change/cancel ANY appointment. **If a hygiene appointment is changed or canceled the 2nd time a \$45 charge will occur. Any appointment more than 45 minutes long will be charged \$60.00 per 30 minutes of scheduled time.**

_____ *Initial Here*

Appointment Reminder Cards

I give Canton Dental Group permission to send a reminder postcard through the U.s. Postal Office.

_____ *Initial Here*

X-Rays

Original x-rays are the property of Canton Dental Group. **If you wish to have your x-rays duplicated, there will be an \$11.00 processing fee.**

_____ *Initial Here*

Collections

If you fail to pay your balance after 90 days, your account will be sent to a collection agency. There will be a **\$50.00** charge to process the collection account and a **20%** collection cost added.

_____ *Initial Here*

By signing below, I understand and agree to the above listed office policies of Canton Dental Group and assume responsibility for all services rendered.

Patient/Parent or Guardian: _____ Date: _____