Le Smile

Aesthetic & Comprehensive Dentistry

Dental Agreement

All quoted treatment plan fees regarding your dental care fees are subject to change over time.

If I, ____, am covered and any dental insurance plan, the information provided is also true and accurate. I also understand that all information provided verbally and/or written to my doctor or any staff member will remain strictly confidential

I, ____, understand that any complications regarding further delay or decline of dental treatment recommended by the dentist will be my responsibility if any dental problems and/or failure of existing dental conditions occur.

I, ____, will be held financially responsible for any dental treatment rendered at the time of service, and aware that there is no guarantee of dental benefit until a claim has been filed by the dentist/ I will also be responsible to pay the full and/or difference of any treatment not covered under my insurance policy.

I, ____, understand that there will be a $45.00 charge for dental records or any medical records which need to be filled out by the physician.

I, ____, also agree to pay a $39.00 fee for missed appointments not cancelled twenty-four (24) hours prior to the scheduled appointment and a $100.00 fee for any procedures not cancelled two (2) days prior to the scheduled appointment.

I, ____, agree that if for any reason a check is returned on my account, I will be held responsible for a $39.00 returned check fee in addition to the original fees for services.

If the balance is not paid within thirty (30) days or if agreed upon payment agreements on my account is not made, the practice will retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies.

I, ____, agree to inform the practice immediately of any change in insurance coverage and/or/ benefits and change of personal information.

Should any balances arise due to insurance, co-payments, co-insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependent to insurance plan, non-payment at the time of service and/or any other reason, I, ____, agree to pay all charges within sixty(60) days of services rendered. Interest of one and one half percent (1 ½%) per month, eighteen (18%) per annum may be charged on all delinquent accounts over sixty (60) days.

Signature: _____ Date: _____