

Financial Agreement

Our mission is to deliver the finest dental care treatment available

As our patient, in consideration of the services received from **Cross Street Family Dentistry**, you agree:

- ✓ To be fully responsible for all expenses incurred for your treatment, regardless of insurance coverage.
- ✓ Full payment or full co-payment is due at the time service is provided.
- ✓ As a **courtesy**, we will file your insurance claims up to 60 days after treatment and verify benefits: however It is ultimately your responsibility to call your insurance company and familiarize yourself with your coverage, follow up on ANY and ALL outstanding claims, and to know any remaining available benefits. All charges incurred are your responsibility regardless of insurance coverage, estimates given by our office, benefits which were verified by our office, or status of claims. All account balances over 90 days are subject for review and possible referral to our collection agency and therefore all three credit reporting bureaus.

We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company. Our office is not a party to that contract or any possible restrictions thereof.

Payment Options for our Patients

In order for us to uphold our mission statement and keep our fees to you as low as possible, we require you to pay for todays and future visits at the time of treatment. However, we do offer several alternative payment options for your convenience:

- Cash, Check, Visa Card, Master Card, Debit Card, American Express and Discover
- Payments Interest free through our office. The remaining balance can be split into payments for the duration of treatment. These remaining payments must be made as scheduled in the initial payment agreement. Payment in full is expected at the time of treatment completion.
- **Sunbit & Care Credit** specializes exclusively in helping patients with larger dental or orthodontic cases. With fast approval from this company, they typically can offer you a smaller monthly fee over a longer period of time, with no down payment and no prepayment penalty than what our office can provide you. Their rates usually range pending individual credit scores.

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS. I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE PROVISIONS. IN ADDITION IF I HAVE INSURANCE, I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR. I AUTHORIZE DAREL MOSS DDS & ASSOCIATES TO RELEASE ANY OF MY MEDICAL AND DENTAL INFORMATION TO MY INSURANCE COMPANY, AS NEEDED TO PROCESS MY INSURANCE CLAIM.

Patient's Name

_____/_____/_____
Date