Asheville Family Dentistry
Callan D. White, DDS, PLLC
Allison J. White, DDS

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. In order for our practice to file your insurance claim, you may be asked to provide proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments.

We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit.

For our patients without dental insurance, we provide written estimate of fees. Payment is expected at each visit for services rendered. If you choose to pay cash in full, one week before the treatment day we will gladly extend a 5% cash savings.

The parent or guardian accompanying the minor is responsible for full payment without any exception.

Returned checks and balances older than 90 days will be subject to collection fees.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____
Print Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date