NORTHWOOD
Family Dental
CENTER

Patient Financial Agreement

Patient Name: _____ Date: _____

Thank you for choosing Northwood Family Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Please review our financial policies below. Your signature at the bottom indicates your understanding and agreement to these terms.

Payment Responsibility:

- **Direct Payment:** All charges are due at the time of service. We accept cash, checks, and major credit cards (Visa, MasterCard, Discover, Amex).
    - Convenient Monthly Payment Options from CareCredit® Healthcare Financing and Medical Credit Card or LendingClub® (subject to credit approval)
        - Allows you to pay overtime
        - No annual fees or pre-payment penalties
- **Insurance Estimates:** As a courtesy, we will file claims with your insurance company. Please note that insurance estimates are **NOT a guarantee of payment**. You are personally responsible for any balance your insurance does not cover.

2. Appointment Cancellation & "No-Show" Policy

Your appointment time is reserved exclusively for you. When appointments are missed or cancelled without sufficient notice, it prevents other patients from receiving care.

- **Notice Required:** We require a minimum of **two business days' notice** for any cancellation or rescheduling.
- **Broken Appointment Fee:** Failure to provide the required notice, or failure to show for a scheduled appointment, will result in a $75 **fee assessed to your account.**
- **Pre-payment for major services:** For major procedures (appointments scheduled for 90 minutes or more), a 50% non-refundable deposit may be required at the time of booking to secure your reservation. Failure to keep your scheduled appointment without the required notice of 2 business days will result in forfeiture of your deposit, if no deposit was collected, a fee equal to 50% of the appointment charges will be assessed to your account.
- **Insurance Restriction:** These fees are the sole responsibility of the patient and **cannot be billed to or paid by insurance**.

3. Additional Fees

- **Returned Checks:** A fee of $50.00 will be assessed for any checks returned by your bank.
- **Collection Costs:** If an account is referred to a collection agency or attorney, the patient is responsible for all associated legal and collection fees.

Acknowledgement

I have read, understood, and agree to the terms of this Financial Policy. I acknowledge that I am ultimately responsible for all professional dental services rendered.

Signature of Patient/Guardian: _____ **Date:** _____

Relationship to Patient: _____