

AZ FAMILY DENTISTRY

5690 W. Chandler Blvd., Suite 1
Chandler, AZ 85226
Ph: (480) 753-1111 Fax: (480) 765-1112

Financial Agreement

Payment is due at the time of your dental services unless other arrangements have been made with the Practice Manager.

As a courtesy we will bill most dental insurance plans. *However, as a patient, it is your responsibility to understand your benefit plan (i.e., maximums, benefit exclusion & limitations plan).* Please be advised we will estimate your dental insurance benefits when possible. You will be responsible for any amount not covered by your insurance.

_____ Initials

We reserve time for each patient. There will be a fee of \$25.00 added to your account if you fail to cancel your appointment within 24 hours. _____ Initials

There will be a fee of \$30.00 for each NSF (non sufficient funds) check that is returned by your bank.

_____ Initials

All patients portions are due upon services rendered. In the case where we are billing your insurance we may send you a statement for the remaining patient portion which is due upon receipt. _____ Initials

For all patient balances that become older than 90 days there will be a late charge of 18% added to the balance of the account. _____ Initials

Methods of payments available

Cash Check Auto Payment Credit Card

Patient/Guardian Signature: _____

Date: _____