



FLORIDA INSTITUTE FOR PERIODONTICS & DENTAL IMPLANTS

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Patient Financial Responsibility Policy & Agreement

Patient Name: _____

Payment Due at Time of Service:

I understand that as a condition of being accepted as a patient by the Practice, the Practice requires payment in full at the time services are rendered by cash, check, credit card or by pre-arranged third-party financing, and I agree that I am personally responsible for all charges incurred. I understand I will receive an itemized estimate prior to service, and have the responsibility to ask any questions I may have regarding such estimate.

Insurance or Third-Party Financing:

I understand that my insurance policy or other third –party financing arrangement is a contract between myself and the insurer or financing company, and that regardless of the extent to which such contract provides coverage for the services I receive, I am personally responsible for all charges. I further understand that practice staff may provide me with assistance in locating available third-party financing companies and/or provide me with an itemized bill necessary for filing for reimbursement with my insurance company, but that such assistance in no way guarantees availability of financing or that my insurance will provide payment. I remain responsible for any amounts not paid by insurance, including co-payments, deductibles, and non- covered charges.

Missed Appointment Charge:

In consideration of the time of the professionals who will provide my care, I understand I must cancel any appointment I have made but cannot attend at least 24 hours in advance. I further understand and agree that failure to cancel an appointment (other than bona fide emergency) pursuant to this policy may incur a charge equal to the scheduled service amount for such missed appointment, at the sole discretion of the practice.

Surgical Deposits:

I understand that, in consideration of the time and efforts provided on my behalf by the practice in order to schedule a surgical procedure, the practice will require a deposit in the amount of fifty percent (50%) of the total estimated charges for that procedure, at the time of scheduling.

mailbox@perio-implant.us

1515 North Flagler Drive, Suite #301 West Palm Beach, Florida 33401 Ph. 561-655-1700

1300 Corporate Center Way, Suite 204 Wellington, FL 33414 Ph..561-792-7084

I further understand that such deposits shall become the property of the practice upon payment, shall not accrue interest in my name, and shall be non-refundable unless I cancel or postpone the procedure, at least five (5) days prior to the scheduled procedure date. Upon cancellation refunds by five day notice (5), in accordance with the practice's policies concerning cancellation refunds, I may be eligible to receive a refund. I understand that upon proper cancellation, the amount of the deposit to be refunded shall be refunded to me within ten (10) days by practice check, and that should I thereafter choose to reschedule the procedure it will be at the then-applicable fee schedule for that procedure.

Delinquent Bills and Collections

I understand that any bills which have remained outstanding forty-five days from date of service shall be considered delinquent and subject to referral to an attorney or a collection agency. I agree to pay all costs of collection, including without limitation court costs, agency fees and attorney fees through all trials and appeals, and interest at the statutory rate on such delinquent amounts.

I, the undersigned, do hereby acknowledge receipt of this policy, acknowledge I have been given ample time and opportunity to read, understand, and ask all questions regarding this policy, and affirmatively accept the terms and conditions herein (either personally if patient or on behalf of patient if guarantor)

Signature: _____ **Date:** _____

If Guarantor, Relationship to patient : _____

Received and accepted:

Florida Institute for Periodontics & Dental Implants

By: _____