Katie Milden Family Dentistry

1815 First Avenue Southeast, Suite 102

Cedar Rapids, Iowa 52402

319-365-9105

Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. **Flexible payment plans of up to 6 months upon approval with Care Credit. Approval must be received prior to treatment date.**
2. **Cash, Check, or Visa/MasterCard**

As a courtesy to you we will gladly process you insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. **Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.**

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $50.00.

I understand if I FAIL to make my appointment or have a SAME DAY CANCELLATION there will be a fee of $50.00 that I would be responsible for.

Signature of Patient and /or Legal Guardian_____

Date_____