Written Financial Agreement

Thank you for choosing Dr. Paul J. Nawiesniak, DDS, PLLC. Our primary mission is to deliver the best dental care available.

Dr, Paul Nawiesniak, **requires payment the day of treatment**. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

A fee of **$35/hr** is charged for patients who do not cancel their appointment with at least a **24-hour** advance notice. **For major procedures we may collect a scheduling deposit of $35/hr in order to hold your appointment which is non refundable if appointment is cancelled with less than 24 hours advance notice.**

1. For your convenience, we will submit a claim to your insurance company, one time for each date of service.

2. We will contact your insurance if they have not responded within 30 days.

3. If your insurance company has not responded to our submitted claim and phone call, the balance will be turned over to you for payment. It will be YOUR responsibility to follow up with your insurance company on YOUR claim.

4. If you have a deductible and/or coinsurance agreement with your insurance, it is YOUR responsibility to know your policy. We will attempt to obtain all benefit information, but there is NO guarantee of coverage on any claim submitted.

5. Your insurance coverage is a contract between you and your insurance company.

6. Any payments you make that are subsequently paid to us by your insurance company will be reimbursed to you, we have up to 60 days to refund you after your insurance company pays our office.

7. Any **balance over 30 days will be subject to a finance charge of 2.0% per month** until balance is paid in full.

8. Any account with balances over 90 days and without an established current payment plan will be sent to a collections agency regardless of the circumstances. You will be responsible for ALL the collection agency's fees.

9. There will be a $35 charge for returned checks.

Please understand all insurance benefits are pre-determined and are not a guarantee of payment from your insurance company!

If you have any questions, please do not hesitate to ask. We are here to help you get the best dental care you need. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named on the insurance benefits otherwise payable to me.

I certify I have read and understand the above policy. I understand that I must do my part to ensure payment of Dr. Paul Nawiesniak's services.

_____ _____

Patient, Parent (or) Guardian Signature Date

Patients Name (Please Print) _____