

Dr. Randal L. Hadfield
3300 North Running Creek Way
Building C Suite 100
Lehi, Utah 84043
801-768-4072

FINANCIAL AGREEMENT

Thank you for choosing Dr. Hadfield as your dental care provider. The following is a statement of our financial agreement, which we require everyone to read and sign prior to any treatment. As a condition of your treatment by this office, please understand that payment of your bill is also considered a part of your treatment.

- *All patients must complete medical history form before seeing the doctor/hygienist.
- *Payment is due in full at time of service.
- *Insurance holders: patients portion is due at time of service.
- *We accept **Cash, Check, American Express, VISA, MasterCard and Discover.**
- *We provide interest free payment plans through Care Credit that provides payments on approved credit for up to six months.
- *We require your account to be paid in full within 60 days. If there is a remaining balance after 60 days, a monthly charge of 1.5percent(18%APR) and a \$5.00 late fee will be added to your account every month.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We bill the insurance as a service to our patients; however, you are responsible to know your benefits and coverage. Please be aware that you are responsible for all services not covered or paid by your insurance company. We cannot be held responsible for what your insurance chooses to cover or not cover.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment possible for our patients and charges what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

I understand that I will be assessed a minimum \$30.00 fee per half hour for failure to keep an appointment or notify the dental office of a cancellation 24 hours in advance. Our intent is not to add financial burden, but to improve accessibility to patients desiring dental care.

I grant my permission to your office that you may telephone me at home or at my workplace to discuss matters related to this form. I have read the entire **Financial Agreement** and have had sufficient time to study and understand it, or obtain legal counsel, if I so desire. I hereby agree to be bound by all of the foregoing terms and conditions outlined hereon. In the event that the terms of this agreement are not met, I agree to pay the principal amount, plus all attorney's fees, court costs, all costs of collection, including 50% of the principal amount assigned to any collection agency.

Signature of patient or responsible party

Date