PAUL L CHRISTIANSON DDS
7135 TURNER ROAD
ROCKLEDGE, FL 32955

FINANCIAL AGREEMENT AND CONSENT

We find that communication with our patients helps us in providing the best service to you. We have taken the time to provide this information. Please make sure you read and fully understand.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED:
We accept cash, personal checks (with proper ID) and major credit cards, including American Express. Returned checks are subject to a service charge of $25.00 and you will lose your privilege to write a check to our office. If an overdue balance has to be forwarded to our collection agency for collection, the responsible party will be responsible for any fees incurred by the collection agency, which is typically 30%.

REGARDING INSURANCE:
The doctor's service is provided directly to you and not to an insurance company. We are preferred providers for United Concordia, Guardian, Metlife, Humana Comp Benefits, and Delta Dental. If we are not a preferred provider for your insurance company, you are responsible for the difference between our fee and what your insurance actually pays. We will file for service directly to your insurance company, however, you are expected to pay any deductible and or copay as outlined in your policy on the date of service. We CANNOT guarantee that your insurance will pay for changes incurred by you.

SPECIAL NEEDS:
It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation arises, please bring it to our attention prior to treatment. We must emphasize that as your dental care provider, our relationship and concern is with you and your health, not your insurance company. We recommend treatment based on your need, not on what your insurance covers. If you have any questions regarding recommended treatment and coverage that you contact your insurance company directly. All charges are your responsibility from the date services are rendered.

CONSENT:
The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary to make a thorough diagnosis. I also authorize the doctor to perform all recommended treatment mutually agreed upon by both parties. I understand that using anesthetic agents embodies a certain risk

BROKEN APPOINTMENT:
If you are unable to make your appointment that you have reserved, you will give the office at least 24 business hours notice of cancellation. If you do not give 24 business hours notice, your account will be charged $30.00 per hour for the time lost

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND CONSENT FORM AND AGREE TO THE TERMS STATED.

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Patient (PRINT) date Patient (SIGNED) date

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Parent/Guardian (if minor) date