Print Form Submit Form

BINGHAM-LESTER DENTISTRY

Contract for Services

Date _____

Patient_____

Responsible Party_____

Address_____

APPOINTMENTS

- Scheduled at a time to be of maximum benefit to the patient.
- Although most of our appointments are during work and school hours, for your convenience, we offer evening appointments.
- If an appointment is cancelled or missed without 24 hour notice during our daily business hours, there will be a $60 charge per hour of the scheduled appointment.

OFFICE HOURS Monday8am-7pm Tuesday8am-2pm Wednesday8am-7 pm Thursday 8am-4pm

____(Initial) **DO YOU HAVE INSURANCE?** **YES**_____ **NO**_____

- The responsible party is directly responsible for all charges including any portion of anticipated insurance payments not paid to this office should we accept assignment of benefits. Our recommendations for treatment are based on each individual patient's diagnosis. These recommendations are made with the patient's best long term interest in mind. They ARE NOT based on the administrative evaluation of the insurance company's dental advisor. In the event that our recommendations and that of your insurance company's dental advisor are not in agreement, the patient will be responsible for the full cost of treatment. As an added convenience, we will provide a breakdown of insurance benefits for your review.
- We will submit all insurance claims for you. We will fully attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact us if your policy has not paid within 30 days.

____ (Initial) **LATE CHARGES**

- All payments are due at the time of service.
- Your treatment plan will include an estimated breakdown of all applicable fees, and we will inform you of all costs before treatment is administered.
- Late charges must be paid in the month assessed to avoid additional late fees and a delinquent account.

_____(Initial) **DELINQUENT ACCOUNTS**

- Returned checks will be assessed a $30.00 fee.
- 60 days delinquent – Patient will be dismissed from the practice.

I hereby certify that I have read and received a copy of the above contract and agree to the terms listed above this

_____ day of _____, 2018.

Responsible party's signature_____(Must be 18 years or older)

Bingham-Lester Dentistry team member's signature_____

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