SOMA
MEDICAL CENTER, P.A.

Commitment to Financial Agreement

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment:

A. Payment in full by cash, check, credit card, or alternate financing is required for each appointment as services are rendered. Please be advised that if a check is returned for insufficient funds your account will be charged ***$25.00 bank fee and a $15.00 processing fee***. A social security number is required from all patients if not paying by cash or if we are filing an insurance claim for you. This information is kept confidential and used for collection purpose only.
B. We will file your insurance claim form and accept payments from your insurance company; provided the deductible and any estimated non- covered fees are paid at each visit.
C. We allow up to ***60 days*** for your insurance company to pay claim. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can. In the event this account becomes delinquent and past due, owing more than **30** (thirty) days from the date of billing. *I hereby agree to pay all costs of collection including but not limited to interest, court costs, service of process fees, reasonable attorney's fees and collection costs as may be necessary.*
D. We value our patient's time therefore we make every effort to see our patients at their appointment time. We appreciate the same courtesy from our patients therefore if you cannot make your appointment time please call us at least ***48 hours*** ahead so that we have the opportunity to schedule another patient. If you do not show up for your appointment without calling our office there will be a $***30.00 BROKEN APPOINTMENT*** fee added to your account.
E. Parent or guardian must be accompany patients under the age of 18 years old.
F. Duplication of x-rays or emailed cost ***$25.00*** and Soma Smiles, Inc. reserves the right to charge for the duplication or emailed records.

Please be aware that nay parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

We appreciate the opportunity to serve you, our valued patient.

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Patient or Responsibility Party Print Date

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Patient or Responsibility Party Sign