Clark Dental Care

Patient Care Cancellation and Financial Agreement

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by Clark Dental Care and I understand that payment is due at the time of service unless prohibited by an existing contract between Clark Dental Care and the insurance company. For procedures that are billed to my insurance I understand that I become personally responsible for the charges in the event that my insurance company does not provide payment within 60 days.

I understand that my insurance company may not cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for, I will endorse the check to Clark Dental within 5 business days. In those instances in which an insurance company has made a partial payment for services, I authorize Clark Dental Care to collect (in cash or credit/debit card) outstanding balances including co-pays, co-insurance, deductibles, and non-covered services.

I understand that Clark Dental Care requires 2 business days notice to cancel or reschedule an appointment and that failure to provide such notice will result in a $25 non-refundable charge.

Name_____

Signature_____ **Date**_____

Witness_____ **Date**_____