FINANCIAL AGREEMENT

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and Drs. Almeida and Bell, and that I am still fully responsible for all dental fees my insurance carrier does not pay (my portion will be estimated at the time of my visit). In the event that I do not have dental insurance, payment in full, is required at the time of service. These fees are due and payable via cash, check, credit card (Visa, Master Card, Discover or American Express) at the time services are rendered, unless a prior financial arrangement has been made and is in writing by Drs. Almeida and Bell and signed by myself.

I also assign all insurance benefits to Drs. Almeida and Bell. Any payments received by Drs. Almeida and Bell from any insurance coverage will be credited to my account. I understand that insurance pays on a "UCR fee schedule," which is not necessarily the same as this office's fee schedule, and that the insurance difference quoted is only an *estimate*, therefore, any difference between what has been quoted and is actually paid by my insurance carrier is my responsibility.

If I pay in full at the time of service, I understand I may receive a discount of up to 5%, and then the insurance check will come to me. In the event it is sent to Drs. Almeida and Bell, I understand that a check from Almeida Dental will be issued to me immediately in the amount of the insurance check.

I understand that all fees quoted will be valid for 3 months from the date of my treatment plan. I further understand that a late charge will be added to any overdue balance and that a service charge will be added to any returned check.

Service Charge: I agree that a service charge will be added to my account on any balance 45 days past due. If I do not pay the entire balance within 45 days of the monthly billing date, a finance charge will be added to the account for the current monthly billing period. The finance charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay a legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Appointments: I agree that a minimum charge will be assessed for failing to show or for changing or canceling my dental or hygiene appointments without prior notification of 48 hours. I understand that this fee covers only a portion of the overhead such as salaries, electric, heat, etc. which still have to be paid whether I am present or not, and this time has been reserved for me.

I hereby provide my consent for routine disclosures of my pertinent health records for processing of my dental insurance claims (if applicable) or for the purpose of consultation with other healthcare providers/specialists as it pertains to my treatment.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Doctor's Signature Date