Dr. David Dykes

1015 Tusculum Blvd.

Greeneville, TN 37743

Financial Arrangement Agreement

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office.

With the understanding that payment for treatment is due at the time service is provided, the following payment options are available. Please determine which option would best suit your needs and check:

- Option A: Cash_____Check_____
- Option B: Master Card_____Visa_____Discover_____
- Option C: Payment Plans (with credit approval)_____

Dental Insurance

As a courtesy, we will file your insurance claim for you. We are a provider with ***Delta Dental*** only, but will file all insurances. We request that you pay your estimated portion as well as the deductible on the day of treatment. We will allow up to 60 days for payment from your insurance carrier. After 60 days, we may ask that you intervene. In this case we will ask that you pay your balance and we will forward any credits to you.

Finance Charges

I understand that any unpaid balance after 90 days will be charged a yearly finance charge of 18%. This finance charge is equal to 1.5% of my outstanding balance per month. Should my account reach collection status (120 days) and no effort is made to pay off my account, my account will be assigned to a collection agency or attorney. If my account is assigned to a collection agency, I will be responsible for **ALL** costs of collection, including court cost and attorney's fees incurred by this office.

Appointments

Should you have a conflict with your scheduled appointment, we ask that you notify our office immediately. Failure to contact us with less than 48 hour notice may result in a charge of up to $100.00.

Thank you for taking time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator will be glad to review the agreement with you at any time.

Patient Signature_____**Date**_____

Financial Coordinator_____