Elizabethtown Periodontics
Robert L. Franklin, Jr., D.M.D.
611 W. Poplar St., Ste. C-9
Elizabethtown, KY 42701
(270) 769-1622

FINANCIAL AGREEEMENT

DENTAL INSURANCE (we will not file with your medical policy): As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- **Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, and not your insurance company.**
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary, and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Should your insurance pay more than estimated, we will promptly refund you; and, if your insurance pays less than estimated the balance will be your responsibility and due immediately.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

NO-SHOW POLICY: We reserve the right to charge the following fees for failure to keep a scheduled appointment without a notice of at least 24 hours:
Surgeries: Up to $500
Appointment with Dr. Franklin: $100
Appointment with Hygienists: $50

FINANCE CHARGES AND COLLECTION FEES: Finance charges of 18% per annum (1.5% monthly) will be applied to all balances not paid within 30 days of the monthly billing date. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all dental treatment and services until revoked by either party in writing.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt.

I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies without any reservations; I agree to abide by the policies outlined herein.

Form completed by:

Name:_____ Signature: _____

Date: _____