Coastal Cosmetic Dental Associates, PA makes every effort to verify your insurance benefits before your appointment. I understand that verification of eligibility and benefits does not guarantee that claims will be paid by my insurance, and that fees provided to me are only an estimate of cost and subject to change based on claims processing. I understand that some routine treatments, including but not limited to: implants, sedation, cosmetic fillers and whitening may not be covered by some insurance carriers. I understand and agree that I will be responsible to pay for services that are not paid by my insurance company.

Coastal Cosmetic Dental Associates, PA is considered a non-participating dental office with insurance carriers. We will gladly file your claims for you as a courtesy however, if your insurance company does not pay, fails to pay timely, or denies a claim, you will be responsible for the charges incurred. You will also be required to pay your estimated out of pocket at time of treatment. If your insurance carrier does not pay the full estimated cost, you will be responsible for any difference. Please inquire at the Front Desk if you have any questions about your insurance carrier.

Coastal Cosmetic Dental Associates, PA requires a 24-hour notice to cancel an appointment. If I fail to cancel an appointment within the 24-hour timeframe, I understand that I may be charged a $50.00 No-Show fee.

Coastal Cosmetic Dental Associates, PA charges a finance charge on any balance that is 60 days past due. This finance charge is set at a monthly rate of 1.5% (18% annual percentage rate) of the average daily balance. Any unpaid finance charge will be compounded into the next billing cycle. I agree to pay finance charges that result in lack of payment on my account.

Should my account become delinquent and turned over to an outside collection agency, I understand that I will be responsible for reasonable attorney's fees and costs of collection. I further understand that if my account is turned over to a collection agency, a 25% fee will be charged to my account by the agency.

AGREEMENT OF FINANCIAL POLICY

I have read and understood the financial policy of Coastal Cosmetic Dental Associates, PA of Little River and wish to have services provided to me.

Signature of Patient:_____Date:_____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize Coastal Cosmetic Dental Associates, PA to release to my insurance company any information that is required to process a claim for services rendered. I hereby authorize that payment of benefits by my insurance company be made directly to Coastal Cosmetic Dental Associates, PA.

Printed Patient Name:_____

Signature of Patient:_____Date:_____

Signature of Coastal Cosmetic Dental Associates, PA, Rep:_____Date:_____