Shane Lu, DDS
242 North Talbert Blvd
Lexington NC 27292

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligations to our practice. We are committed to providing you with the most comprehensive dental care. We ask that all **self-pay** patients pay their account in full at the time of service. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always **recommend** treatment based upon your dental needs, not based on your insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment. As we work with you to reach your optimum oral health, we do require that the estimated co-payment for treatment be paid at time of service. This is the portion of our fees that your insurance coverage does not assist you with. Timely payment of patient estimated co-payments ensure that we can keep our administrative cost low, resulting in lower fees for our valued guests.

Your estimated co-payment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, Mastercard, Visa, and Care Credit. Returned checks and balances older than 60 days will be subjected to collection fees and financial charges.

Our practice will accept an assignment of benefits from your insurance company and it is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend in an effort to save you time and facilitate payment to our practice from insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation.

Insurance payments are received within 30-60 business days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time and you will be responsible for seeking reimbursement from your insurance company.

Our practice does not guarantee that your insurance company will assist you with payment for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount at that time. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company request to sort out any confusion or questions that may arise. It is your responsibility to resolve any type of dispute over payment made or not made by your insurance company to our practice.

Cancellation and rescheduling dental visits
Our office does require 24 business hours notice to cancel/reschedule existing visits with us.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT AND I AUTHORIZE MY INSURANCE COMPANY TO PAY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

_____
Print Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date