

**Financial Agreement**

(Please check A or B as applicable and sign below)

**A With Dental Insurance-** please read and check the following option

If you have dental insurance we will gladly file it for you. We request that you pay your “patient portion” today, on the day of treatment, which is the estimated amount your insurance will not cover. We will verify your benefits and inform you of this amount on the day of your appointment or you may call your insurance company for this information. Once insurance pays, we will send you a statement or refund as needed to reconcile your account.

\_\_\_\_\_ I have insurance and will pay my estimated “patient portion” by cash, check or credit card today.

**B Without Dental Insurance-** please read and check one of the following options

I do not have dental insurance and will pay by:

\_\_\_\_\_ Cash payment in full on the day of treatment- receive a 5% discount (no checks please)

\_\_\_\_\_ CareCredit Interest free plan for 3 months (high approval rating)  
Please ask for an application if you are interested.

\_\_\_\_\_ 50/50 plan- pay 50% today by cash, check, or credit card  
pay 50% next month with a post dated check or credit card  
We accept Visa, MasterCard, Discover and American Express.

**Assignment of Benefits for Insurance Checks**

I hereby instruct and direct my insurance carrier to pay by check made out and mailed to Southeastern Endodontics. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Southeastern Endodontics, 2030 Hamilton Place Blvd., Ste. 380, Chattanooga TN 37421

For the dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Southeastern Endodontics to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand the above. I agree to the payment option I have selected and agree to pay any and all collection, attorney fees, court cost, interest fees (5% per month after 90 days) and/or any other additional fees should my account be turned over to any attorney, Collection Service Agency or Transworld. I understand I am paying an “estimated” amount and I am responsible for any remaining balance after insurance pays. I realize that I am also responsible for a \$20 service charge for any returned check.

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date