Dr. Andrew Miller & Dr. Francisco Darquea
1714 N. Circle Dr. Colorado Springs, CO 80909
Phone (719)632-6001 Fax (719)352-3871
www.SmileCOS.com
LifeIsBetter@SmileCOS.com

Financial Agreement

Name: _____Date: _____

Your dental health is our top priority. The purpose of this letter is to provide you with an estimate of fees for the dental services recommended by Dr. Miller and Dr. Darquea. Please understand that this is only an estimate. The course of treatment may need to change for a variety of unforeseen reasons. Every effort will be made to inform you if a change in treatment becomes necessary.

With regard to estimating the patient balance for those with insurance, we would like to stress that we are only able to provide an estimate based on the information provided to our office by you and/or your dental carrier. Your insurance company may dictate that non-covered procedures are billable at office fees instead of insurance negotiated fees. If your dental plan pays more than expected, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your financial statement. If eligibility is denied, the full balance becomes your responsibility.

Any unpaid balance may be forwarded to a collection agency and is subject to interest at 1.5% per month (18% per annum), all costs of collection activity including collection fees in the amount of 30% of the principal balance due, reasonable attorney fees and court costs.

I understand that responsibility for payment for medical services in this office for myself and my dependents is mine: due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection. **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to The Center for Family & Cosmetic Dentistry and authorize the submission of claims without obtaining my signature on each claim submitted.

_____

Patient Signature or (Guardian) Date