DATE: _____

PATIENT: _____

PARENT/GUARDIAN: _____

VALERIE D HUBBELL DDS FINANCIAL AGREEMENT

At DR. VALERIE HUBBELL'S DENTISTRY we are concerned about your dental health. We look forward to helping you with your dental care. Please remember that your dental insurance is **your responsibility**, but we are here to help. We will be happy to file your insurance for you. However, **you must pay your estimated portion at the time services are rendered**. Please remember that this is only an estimate and if your insurance fails to pay what we estimate, it is **your responsibility to pay the difference**. We are committed to providing you the highest quality care regardless of insurance.

We offer FOUR wonderful payment options:

1) Credit Cards
2) Patient Financing through Care Credit
3) 5% courtesy deduction for all treatment paid with Cash or Check in full, (lab fees excluded if applicable).
4) ½ when scheduling treatment, weekly/monthly Payments so treatment is paid for at the end of treatment.

I understand the above policy and any questions have been answered to my satisfaction. **I understand that I am responsible for payment at the time services are rendered. I further understand 24 hours notice is required for cancelled or failed appointments, or a fee will be assessed.**

_____

Patient/Guardian Signature (Children under 18)