Financial Agreement

I agree to be solely responsible for full payment of usual and customary fees charged by Vaughn A. Lee DDS Inc. and/or any independent contractor dentist or employee dentist providing dental care in the same office.

Insurance Benefits Patients

I understand that my responsibility for full payment of my total balance is binding regardless of any preconceptions implied as to the amount my dental insurance may contribute towards the amount of my bill. I have the right to request this office to pre-authorize my insurance company prior to treatment to estimate the balance amount I am responsible for. I understand that it is not usual nor customary for dental offices including this one to pre-estimate or to determine eligibility for routine new patient and recall services such as exams, diagnostic x-rays and cleanings.

I understand that the pre-estimates and determination of eligibilities are not guarantees that my insurance company will honor its pledge, should benefits administrators err on the phone or on written estimates. If there is a dispute or discrepancy regarding the amount the insurance paid or not paid and what I believe my benefits should be, then it is my responsibility to clarify and rectify with my insurance company.

If after sixty days since billing my insurance has not yet remit payment, I agree to pay the full amount within five working days if requested by this office. Any subsequent payment from my insurance company will then be returned to me.

If I do not have insurance benefits, I have the right to request an estimate of the amount to be charged for each procedure to be performed prior to the day of appointment. I understand that this office will provide a five percent bookkeeping fee discount for cash, check, or credit card payment for procedures performed on the same day.

If I have Denti-cal or Healthy Family coverage, I understand that I will be charged the fee allowed for each completed procedure should it be determined that I was not eligible to receive dental care or that there was a denial of payment for procedures such as cleanings or fillings because I have not met the terms of my waiting period.

I understand that I may be charged interest in the amount of 1.5% per month for unpaid portions 90 days past due. I have the right to request a copy of this agreement.

I have read and understand completely the above outlining my financial obligation for services rendered. I am signing this agreement as the responsible party for the patient named below:

Patient's name(s):_____

Responsible Person's Signature:_____ **Date:**_____