HEALTHY SMILES OF DELAWARE, P.A.

1700 Shallcross Avenue
Suite 2
Wilmington, DE 19806

Patrick F. Sweeney, III, DMD

Financial Commitment

Our office submits insurance claims as a courtesy to our patients. As a patient, you are responsible for all dental fees regardless of the insurance coverage.

We require that upon your first visit to our office that you bring all your x-rays from your previous dentist. Otherwise, we will take the necessary x-rays at this first visit, to find areas that may need treatment.

We expect payment from you for the full fee less the anticipated insurance allowance. Remember that because this allowance is merely an estimate, it may vary from the actual benefit paid. The difference is your responsibility and will be billed to you. There is a billing fee involved in sending out statements. The billing fee is $10.00 per month for any unpaid balance.

It is imperative that you supply our office with up-to-date insurance information. Please inform us whenever there is a change in coverage. Remember, you are responsible for the fees accrued. It is to your benefit to verify that we have the correct information when submitting claims to your insurance provider; so they pay the benefit you expect. If the claim is denied by the insurance company, then your full balance is immediately due. Resubmission of a claim or new submission to a new insurance company and or to a secondary insurance will be completed to reimburse the patient.

Patient's co-payments are due at the time of service. Your appointment is valuable time to you and our office. Please call the office when you cannot keep your scheduled appointment, so as to allow the staff enough time to fill your appointment time in the schedule. ***This does not include Friday, Saturday, or Sunday, as we are not here to fill the schedule.*** Rescheduling or cancelling less than 48 hours in advance, or not showing for your appointment, will result in a missed or broken appointment. Missed or broken appointments will be charged a fee of $75.00 per half hour or portion there-of.

In the event that your account goes to collections, you will be held responsible for all collections cost, late fees, service charges, court costs and attorney fees incurred to collect the debt.

Your signature on the line below confirms that you have read and understand this form and that you accept responsibility for the balance on your account for all professional services rendered.

Individuals under my account that I accept Financial Commitment for, (please print each name):

1._____ ( ) Initial 4._____ ( ) Initial

2._____ ( ) Initial 5._____ ( ) Initial

3._____ ( ) Initial 6._____ ( ) Initial

_____ _____

Patient / Responsible Party Signature Date