Sarasota Center for General and Cosmetic Dentistry
Financial Responsibility Agreement
(Please initial each and sign below)

_____ I understand that fees for services rendered are due at time of appointment. This includes insurance deductibles and patient's portion not payable by insurance.

_____ I understand that as part of the financial arrangement process, I will be provided with **estimates** of what my insurance company will pay. In the event that my insurance company denies payment of a service or pays less than the estimated, I am responsible for that fee.

_____ We accept MasterCard and Visa as well as personal checks and cash. There is a $30.00 charge for any returned checks.

_____ I understand my account will go past due within 60 days of my last visit. It will be turned over to collections at 90 days past due a I would be responsible for the fees that incurs.

_____ I assign dental benefit payments to be paid directly to Dr. Francisco Marcano-Soltero from my insurance company.

_____ **There is a $30.00 reservation fee required for all appointments scheduled.** A $50.00 per ½ hour fee is required to reserve all appointments scheduled for **two or more hours.** These fees will be applied towards treatment rendered. If this appointment is canceled or failed without a 48 hour notice; the deposit will be used for a failed appointment fee.

_____ I understand there is a failed appointment fee of $30.00 for any appointment canceled or failed without 48 hour notice.

_____ I understand there will be a $10.00 copy fee for any X-ray films and/or dental records released from this practice.

Name ______________________________

Signature______________________________ Date__________________