LABUZ DENTAL INC.

FINANCIAL POLICY & DENTAL INSURANCE AGREEMENT

Our goal is to provide you with quality dental care while helping you maximize your dental insurance benefits. Please review our financial policy below.

1. PAYMENT POLICY
Payment is due at the time services are rendered unless prior arrangements have been approved by our office. We accept cash, checks, Mastercard, Visa, and American Express.

2. DENTAL INSURANCE
As a courtesy, we will submit insurance claims on your behalf and assist you in understanding your estimated benefits. Insurance coverage is not guaranteed, and estimates are not a guarantee of payment. Your insurance policy is a contract between you, your employer, and your insurance company. Labuz Dental Inc. is not responsible for insurance company decisions, limitations, or delays.

3. PATIENT FINANCIAL RESPONSIBILITY
You are responsible for all charges for dental services, including deductibles, copayments, and services not covered by insurance, regardless of insurance reimbursement. Any insurance payment arrangement accepted by our office does not eliminate your responsibility for outstanding balances. Monthly statements may be sent for any remaining balance.

4. INSURANCE COVERAGE & TREATMENT
Not all dental procedures are covered by every insurance plan. Insurance companies may limit or exclude certain treatments. Lack of insurance coverage does not mean that treatment is unnecessary. Our office will gladly discuss proposed treatment and estimated insurance benefits; however, final coverage is determined by your insurance company.

5. ACCOUNT BALANCES & FEES
Returned checks are subject to a $35 fee. Balances outstanding for more than 60 days may be subject to a 5% monthly finance charge, where permitted by law. Please contact our billing department promptly if you experience difficulty paying your balance.

6. APPOINTMENT CANCELLATIONS
At least 24 hours' notice is required for appointment cancellations or rescheduling. Cancellations with less than 24 hours' notice may be subject to a $100 fee, subject to applicable law.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have read, understood, and agree to the financial policies of **Labuz Dental Inc.** I understand that I am responsible for all charges incurred for services provided, regardless of insurance coverage or payment.

Patient Name (Print): _____

Patient Signature: _____

Date: _____