Keith L Stucki DMD, MS

General Financial Agreement

Thank you for choosing our office for your dental needs. In an effort to provide quality care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered. We require **24 hour notice** of change or cancellation of appointment. In the case of short notice cancellations or broken appointments, you will be charged a **$50 missed appointment fee.**

Financial Options:

1. **Payment in full at time of service** - you will receive **5%** off of your balance when paying by **Cash** or **Check**.

2. We accept: **Cash, Check, Debit, Visa, MasterCard, American Express and Discover.**

3. **Care Credit:** Our practice offers a flexible payment program called **Care Credit**. It's very quick and easy to apply for. With this program you can make low monthly payments, choose between several payment plans, and pay no money up front. There are also interest free plans to choose from.

   *Please inquire about pamphlet and application if interested. You can also apply on line at www.carecredit.com.

As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by your insurance is the **responsibility of the patient and is due at the time the service is rendered.** This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference and payment is due within **30** days.

Insurance Authorization – Signature on File – for insurance benefits only:

I hereby authorize **Keith L. Stucki, DMD** to release any information relating to all claims for benefits on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered without obtaining my signature on each and every claim for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that it is my responsibility to inform the dental office if any changes occur in my insurance coverage.

I have read the financial policy/Signature on File and agree to all terms and conditions.

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Name of Patient (Please Print)

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Signature of Patient/Parent/Legal Representative Date