



Ryan S. Kinn, DMD, LLC
FINANCIAL AGREEMENT FOR PATIENTS

SECTION A: PATIENT INFORMATION

Patient Name: _____ **Patient Number:** _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Financial Responsibility: This Agreement outlines the financial policies for dental services rendered at Ryan S. Kinn, DMD, LLC. Unless otherwise agreed to in writing, the financial responsibility for all charges incurred for patients under the age of 26 will be the responsibility of the account holder. At the age of 26, if not requested earlier by the patient or account holder, the financial responsibility will automatically shift to the patient.

Payment: Payment is due in full at the time of treatment unless prior arrangements have been approved by our office.

Insurance: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office will process your insurance claim forms. You are still responsible for the full payment of services rendered. This includes any co-payment and deductibles that your insurance does not cover. You authorize Ryan S. Kinn, DMD, LLC to receive payment directly from your insurance company for benefits otherwise payable to you. In the event your insurance remits payment directly to you, you are obligated to forward that payment to Ryan S. Kinn, DMD, LLC immediately.

Authorization: By signing this Agreement, you acknowledge that you are responsible for all costs associated with your dental treatment. You also authorize Ryan S. Kinn, DMD, LLC to release any information, including diagnosis and treatment records, to your insurance company and agree to billing by regular mail, email and text message.

Credit Check and Employment History: By signing this financial agreement, I understand and agree that Ryan S. Kinn, DMD, LLC is authorized to check my credit and employment history.

Late Fees and Collections: A late fee of \$5 per month will be applied to your account if your balance remains unpaid for 30 days. If your account becomes delinquent, you will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

Cancellation Policy: We require a minimum of 24 hours notice for appointment cancellation. In the event you cancel your appointment with less than 24 hours notice, a late cancellation fee of \$20 will be applied to your account. If you miss your scheduled appointment entirely without prior notification, a no-show fee of \$30 will be charged.

Payment Methods: We accept cash, personal checks, money orders, all major credit cards and Care Credit as payment methods. Please be aware that returned personal checks are subject to all associated bank fees.

Agreement: *By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this financial agreement.*

Patient Signature: _____ **Date:** _____

(If this consent is signed by a personal representative on behalf of the patient, complete the following)

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS AGREEMENT AFTER YOU SIGN IT.
Include completed Agreement in the patient's chart.**