ENDO GROUP

MAHNAZ MESSKOUB DDS MS PA
PEDRAM BOHLULI DDS MS PHD
SHADI ABEDIN DDS CAGS
NICK KHALILKHANI DDS MS

Patient's Name: _____
(Please Print)

Financial Agreement

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you or your dentist. Our philosophy in serving people is to be informative, honest and forthright. This financial agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our financial agreement please do not hesitate to ask our business office staff.

Dental Insurance: As a courtesy we will gladly file your claims and accept assignment of benefits provided you agree to the following:

- You must provide us with your insurance and all the necessary information to verify your coverage and file your claim.
- You are responsible for our "usual customary and reasonable" fees or contract fees with your insurance, if any. Contract fees may vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefits amounts, limitations, exclusions, waiting periods, etc. is entirely **Your** responsibility. Receiving your service indicate your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

Payments:

- We accept cash, personal checks, money orders, debit cards, Visa, MasterCard, Discover, American Express, Care Credit and Chase Health Advance.
- After dental insurance has paid its portion, a statement, if any, is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date.
- If the insurance company does not pay in full within 90 days, it will be your responsibility to pay the balance.
- We don't file claims for medical insurance.

Patients Without Insurance Coverage: We provide written estimate of fees, and payment is expected at each visit for services rendered, unless otherwise specified.

Minor Patients: The parent or guardian accompanying the minor is responsible for payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at the time of visit, unless arrangements are made with the office.

Returned Checks: A charge of $35.00 is applied to your account, when the bank returns a check.

Overdue Balance: An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt.

Broken or Missed Appointments: Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments will be rescheduled and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them very seriously so please be considerate and inform us in advance if you need to change your appointment. There is a missed appointment fee of up to $40.00. We reserved the right to terminate professional treatment of any patient when scheduled appointments or not kept.

Patient's Signature: _____ **Date Signed:** _____

9400 Westheimer • Suite no. 1 • Houston TX 77063
P 713.932.7730 F 713.932.7244