Financial Agreement of
De Queen Dental

Last Name: First Name: Birthdate:

*I agree to be financially responsible for all charges; for all services & materials not paid or covered by my dental insurance plan. This may appear as a surcharge on your statement.

*For my convenience, this office may release my information to my insurance company and receive payment directly from them.

*I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

*If sent to collections, I agree to pay all related fees and court costs.

*As a courtesy, De Queen Dental will make every effort to help collect payment from my insurance company, but if they do not pay as expected and in a reasonable time frame, less than 90 days I will still be financially responsible for payment. In some situations (Out-of-network insurance plans) I maybe responsible for my balance upfront, then reimbursed by my insurance company.

*I agree to pay finance charges of 1.5% per month (18% APR) on balances 90 days past due.

*I agree to pay a $25 fee for appointments broken without a 24 hour notice. This fee must be paid before I can schedule another appointment.

*After 3 missed appointments, I will be dismissed from De Queen Dental.

*Treatment plans may change, and I will be responsible for the work actually done.

Patient Signature: _____ Date: 08/02/2023