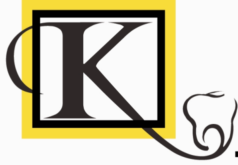

Dr. A.M. Kahane, Inc

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FINANCIAL AGREEMENT

The Association of Dental Surgeons of British Columbia provides a **guide** that is used to help us establish our fees. Our fees are determined by the cost and complexity of the procedure, and the time involved to do that procedure.

It is very important that you understand that when your insurance card says you have 100% or 50% coverage that means THEY PAY THAT % OF THE FEE THEY ALLOW which may not be the same as our fees. This could result in an unpaid portion which is your responsibility. This amount is due and payable at the time of treatment.

Please understand that if you have dental insurance, any agreement is between you and that insurance company or you and your employer, and NOT BETWEEN THE INSURANCE COMPANY AND THIS OFFICE.

For those of you with dental insurance, as a courtesy we will be happy to process your insurance claim forms (assignment of benefits). In order for us to do assignment of benefits you must provide the dental office with your dental insurance information. Although we ask only for any uninsured portion to be paid at the time the service is rendered, we do emphasize that the **ENTIRE AMOUNT IS ULTIMATELY YOUR RESPONSIBILITY.** Note that there are a number of insurance policies from whom we will not accept assignment due to difficulty in collecting from them.

We encourage those of you with dental insurance to pay the full amount at the time of service. If you choose to pay by credit card you may be able to take advantage of credit card “bonus points” and have the insurance company reimburse you directly. In most cases payment from insurance companies can be expected within two weeks or less(often within 3-5 days if you have direct deposit set up with your insurance).

For your convenience we accept cash, cheque, Interac, Visa, Mastercard and American Express. Accounts over 30 days will have 3% interest applied.

I certify that I have read and fully understand the above financial agreement.

Patient Name:____

Signature of Patient:____

Signature of Parent/Guardian of Minor Patient:________________________

Name of Witness:____

Signature of Witness:____

Date_________________________