THOMAS
DENTAL GROUP

FINANCIAL AGREEMENT & PATIENT RESPONSIBILITY

I understand that payment for dental services is due at the time services are rendered unless prior arrangements have been made. I agree that I am financially responsible for all charges incurred for dental services provided to me or my dependents.

I understand that dental insurance is a contract between me and my insurance company. As a courtesy, this office may submit insurance claims on my behalf; however, I am ultimately responsible for all charges not paid by insurance. Any estimates provided are not a guarantee of payment.

I understand that missed appointments or late cancellations affect our dental team, scheduled treatment time, and other patients seeking care. I agree to provide adequate notice if I am unable to keep my appointment.

I understand that returned checks may be subject to additional fees. Accounts with outstanding balances may be subject to collection efforts in accordance with Ohio law, and I agree to be responsible for reasonable costs of collection as permitted by law.

☐ I have read and understand this financial agreement.

☐ I agree to be financially responsible for all charges incurred.

Patient / Parent / Legal Guardian Signature: _____ Date: _____

Printed Name: _____

reception@thomasdentalgroup.net

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