Olim and Associates
Dr. Marvin Olim and Dr. Sarah Olim
1615 South Fry Road
Katy, Texas 77450
(218) 492-6546

Treatment & Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available on the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full.

Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company in your behalf. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation of your treatment.

We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

We require you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide services to you. The copayment is only an estimate of charges and may be found to be insufficient after your claim is processed by your insurance company.

Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Your insurance may contain clauses that affect the amounts paid by your insurance. Olim and Associates will notify you of such clauses whenever possible; however, it is your responsibility and not Olim and Associates responsibility, to be aware of these clauses for your particular insurance and the effect on the amounts due. For example, if an alternate benefit clause states that your insurance will only pay the cost for an amalgam (silver) filling not a composite (white) filling. Your responsibility for charges in this case would be the cost the composite filling minus the cost the insurance will pay for an amalgam filling and your copay. You would be responsible for the remaining difference.

Please initial each statement and sign below as acknowledgement and acceptance of these policies.

_____ *I have read and understand the Treatment & Financial Agreement for O & A.*

_____ *I agree to consent to services as recommended by the Doctor.*

_____ *I understand it is my responsibility to comply with the recommended treatment plan and to maintain my oral health. Failure to follow the recommended treatment plan may result in dismissal as a patient.*

_____ *I have read and understand the financial policies of the practice and agree to be bound by the terms.*

_____ *I have read and understand the insurance information provided to me and acknowledge that specialized clauses may change the amount paid by my insurance and increase the amount I owe.*

_____ *I certify that all information I provide is true and correct to the best of my knowledge.*

_____ *I understand it is my responsibility to notify O & A of any changes in pertinent information.*

_____ *I understand any of these policies may be amended by the practice from time to time.*

_____	_____	_____
Printed Name of Patient/Parent/Guardian	*Signature of Patient or Responsible Party*	*Date*
_____	_____	_____
Printed Name of Witness	*Signature of Witness*	*Date*