

**FRIENDLY SMILES FAMILY DENTISTRY**  
**Dr Brenda Barfield, DDS**  
**2701 9th Ave SW Suite F**  
**Fargo, ND 58103**

**FINANCIAL POLICY**

Thank you for choosing Friendly Smiles Family Dentistry as your dental care provider. We are committed to your successful treatment. Please read our financial policy carefully and sign at the bottom to proceed with your appointment.

**PAYMENT**

Payment for our services is due at the time of your visit. We accept cash, personal checks, Visa, Mastercard and Discover.

**INSURANCE**

If you have insurance coverage, we can process the insurance claim for you, and give you an estimate for the patient portion of your bill. This portion is due at the time of service. If we do not receive payment from your insurance company within 45 days, or if the insurance coverage is less than we estimated, we will send you a bill for the outstanding amount. If we overestimated the patient portion, we will promptly refund the difference upon request or credit is applied to account for future use.

Patients are responsible to know their Insurance plan. Friendly Smiles Family Dentistry, PC is not liable for anything denied or not covered by your insurance plan. When given a treatment plan in writing or verbal we are estimating insurance benefits and is not a guarantee of payment.

**LATE PAYMENT**

In the event your account becomes past due, we will assess a late charge equal to 1.5% per month of your outstanding account balance. If your account becomes overdue by more than 60 days, it will be referred to an outside collection agency. You will then be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by Friendly Smiles Family Dentistry in collection of the payment.

**RETURNED CHECKS/INSUFFICIENT FUNDS**

Checks that are returned as a result of insufficient funds or account being closed/suspended, will be assessed a **\$25** processing fee.

**APPOINTMENT CANCELLATION/MISSED APPOINTMENT**

Your account will be charged a **\$75** fee for missed appointments unless we receive notification at least 24 hours in advance.

PLEASE INDICATE BELOW THAT YOU HAVE READ AND UNDERSTAND OUR FINANCIAL POLICY.

I have read and understand this policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Who referred you to our practice? \_\_\_\_\_