Donald J. Arima, D.D.S., P.S.

FINANCIAL ARRANGMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, we require payment at the time of treatment. We ask that you read and sign this statement prior to any treatment.

YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF TREATMENT. We accept cash, check, Visa, MasterCard and Discover credit cards. For extensive treatment plans, we offer extended payment plans with outside financing at low interest rates with prior credit approval.

REGARDING INSURANCE

We will gladly file all dental claims for given treatment but we are not partial to any insurance programs or contracts. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage. After 60 days, it is the patient's responsibility for the balance of the account.

MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least 48 hours in advance if you cannot keep your scheduled appointment. There will be a charge if a cancellation is made on the day of the appointment.

FINANCE CHARGES

I understand that any unpaid balance after 90 days is charged a yearly finance charge of 12%. I further understand that this finance charge is equal to 1% of my outstanding balance per month. I understand that if my account reaches collection status and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency.

Date_____ Signature:_____

Thank you for taking the time to read and understand our financial agreement. Our financial coordinator would be glad to answer any questions or review this agreement with you at any time.