

**Lewiston Family Dental**  
850 Center Street  
Lewiston, NY 14092 754-4810

***Payment Agreement Terms and Conditions***

This agreement is made as of the date referenced below by and between Lewiston Family Dental, with offices located at 850 Center Street, Lewiston, NY and the undersigned patient for the purpose of outlining the parties' rights and responsibilities with respect to the payment and collection of outstanding balances not covered by the Patient's dental insurance.

In the event that the Patient does not have dental insurance coverage for the services provided by Lewiston Family Dental, the Patient hereby agrees that all charges associated with said rendered services shall be paid in full ***on the date of service.***

Where dental coverage is available to the Patient, as a courtesy, our office staff will submit charges associated with the services provided to the Patients insurance provider. Any uncovered dental expenses will be the sole responsibility of the patient. Unless otherwise agreed to by Lewiston Family Dental, all outstanding co pays, deductibles and any other related fees or charges will be paid in full on the date of service.

A Non Sufficient Funds Fee in the amount of \$20.00 shall be assessed to a patient for each returned check.

**If a patient does not show or call to cancel (within 24 hours) a scheduled appointment, a \$25 missed appointment fee will automatically be assessed.**

In the event that the patient does not pay in accordance with the terms and conditions outlined above, the patient hereby acknowledges and understands that an additional monthly service and billing charge of \$3.00 will be added to the patient's outstanding balance for each month the patient maintains a balance.

All outstanding balances more than 90 days overdue will be sent to collection. In such event, the Patient hereby agrees that they shall be responsible for any and all costs of said collection including, but not limited to collection agency fees, filing fees, court and attorney's fees, and any other fees associated with said collection.

By signing below, the patient hereby acknowledges, understands and agrees to the above referenced terms and conditions.

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_

Patient's Printed Name \_\_\_\_\_

Cc: patient \_\_\_\_\_