FINANCIAL INFORMATION

Michael C. Cordora, DDS, PLLC
236 Ninth Avenue Drive North East
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828-324-9800Office 828-324-9890 Fax

Please read the following information carefully!

If you **have dental insurance** it will be filed by this office. We will also accept assignment of benefits. We never know exactly what or how much your insurance coverage will be. An **ESTIMATE** of what you and your insurance company should pay will be given to you. Once the insurance company reimburses us, if a balance remains on your account, you will be billed for the balance. We will make every effort to work with your insurance company and ask for your patience in doing so. If your insurance company does not make a payment on a claim **you are responsible for payment in full within 30 days.**

If you **do not have dental insurance,** full payment will be required at the time of service, unless **prior** arrangements have been made.

I understand that I am financially responsible for any remaining balance on my account, including whatever my insurance company does not pay on services rendered.

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I understand that a broken appointment fee may be charged for appointments missed or not cancelled within **one business day's notice.**

I understand that my account will be turned over to a collection agency if not paid in full within 90 days of treatment.

Patient/Guardian Signature_____ Date_____