MARSHALL B. YOUNG, D.D.S.
FAMILY AND COSMETIC DENTISTRY

Financial Agreement

PLEASE READ COMPLETLY, INITIAL EACH SECTION AND SIGN AT THE BOTTOM

Appointments

Our practice is dedicated to quality care and exceptional service. Dr. Young and staff spend extensive amounts of time preparing for your appointment. Broken, late and missed appointments create scheduling problems for our team as well as other patients. If you find you must change your appointment, we request you give at least **72 hours notice** so we may make every effort to accommodate other patients. If appointments are canceled/rescheduled without adequate notice, **a cancellation fee of $50.00** may be applied to your account.

(Initials_____)

Insurance

I understand that Marshall B. Young, DDS, Inc. is *currently* only in network with Delta Dental Premier, however, **this change effective January 1st, 2025,** when we will **no longer participate in Delta's network**. I understand that Marshall B. Young, DDS, Inc. accepts and files insurance claims on my behalf for all PPOs as an **Out-of-Network Provider**. I acknowledge that I have confirmed with my insurance company and am aware of my network standing. I understand that Marshall B. Young, DDS, Inc. will file my insurance claim as a courtesy to me and that any quote for my portion is only an estimate, and ultimately it is my responsibility to understand the details of my insurance policy. I agree to be financially responsible for the portions of payment that my insurance company does not pay for me. This may include co-pay's, uncovered procedures and are subject to insurance limitations, annual deductibles and plan maximums.

Marshall B. Young, DDS, Inc. **does not accept any HMO** plans, therefore if I am part of an HMO, I will have to pay 100% of my bill.

(Initials_____)

Non-insurance

If you do not have any dental insurance (or become uninsured), payment will be due at the time services are rendered. We accept cash, check and all major credit cards.

(Initials_____)

I have read and understand the above statements and acknowledge I will abide by these policies.

_____ _____ ____/_____/_____

Signature of Patient, Parent, Guardian | Please Print Name | Today's Date