John D. Stockman DDS, PA
2051 Greenhouse Rd. Suite 200 Houston, TX 77084
Phone: 281-463-0339

Financial Agreement

Thank you for selecting Dr. John D. Stockman DDS, PA as your healthcare provider. We are honored by your choice and we are committed to providing you with the highest quality of healthcare.

We ask that you provide us with the most correct and updated information about your insurance. You will be responsible for any charges incurred if the information is not correct.

Your dental benefits are based upon a contract made between your and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or dental insurance directly.** Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We estimated your portion based on the most up to date information we have, but it is only an estimate. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require. This can also change due to deductible information or changes to your policy.

We require payment in full for your portion at the time of service unless we have personally arranged otherwise. We accept...MasterCard, Visa, American Express, Discover, cash, checks. We do not accept CareCredit or others alike.

A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask you give at least 24 hour advance notice. After 3 rescheduled and or failed appointments, we may not be able to advance schedule your appointment and instead you would be asked to call the day of to see if there are any openings and be fit in.

Patients may also incur and are responsible for the payment of additional charges. These other charges could include charges for returned checks and any cost associated with collection of patient balances.

We welcome you to our office and look forward to helping you achieve a healthy, beautiful smile!

By my signature below, I hereby authorize Dr. John D. Stockman DDS, PA and staff associated, to release medical and other information acquired in the course of my examination and or treatment to the necessary insurance companies and third party contracts. We DO NOT sell your information to anyone.

I understand that I am financially responsible for all charges incurred at this office.

_____	_____	_____
Printed Name	Signature (parent if minor)	Date