PROFESSIONAL LANE DENTAL ASSOCIATES

102 Professional Lane
Dothan, AL 36303

NEW PATIENT FORM

PATIENT NAME:_____ DATE OF BIRTH: _____

RESPONSIBLE PARTY: _____ DATE OF BIRTH: _____

AGREEMENT TO PAY:
You will be expected to pay deductibles and co-pays at the time of service. We accept cash, checks, credit cards, Care Credit & Citi Healthcard.

The undersigned accepts the fees charged as a legal and lawful debt and agrees to pay said fees, including any/all collection agency fees, (33.33%), attorney fees and/or court fees, if such be necessary.

You agree, in order for us to service your account or to collect monies you may owe, PROFESSIONAL LANE DENTAL ASSOCIATES and/or our agents, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that PROFESSIONAL LANE DENTAL ASSOCIATES, its employees and/or agents may contact me/us as described above.

_____ _____
Responsible Party Signature Date

Appointments that are cancelled with less than 24 hour notice may be subject to a $40.00 broken appointment fee. Initial _____

All deductibles and co-payments are due on the day of treatment unless prior arrangements have been made with the Office Manager. Initial _____

I have received a copy of this office's Notice of Privacy Practices Initial _____