OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

As a courtesy to our patients with insurance, we will file your dental claims for services rendered. You are responsible for paying any deductible, copayment, and patient portion at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. After 45 days if your insurance has not paid, the remaining balance becomes your responsibility and you will need to seek reimbursement from your insurance company. You will be given 45 days to pay your balance in full before your account is sent to collections.

A service charge of 2% per month (24% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a wavier of any breach of any time or condition hereunder shall not constitute a wavier of any further term or condition. Should my account be turned over for collections, I agree to pay all costs to collect the debt, including, but not limited to, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party collections agency. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc, to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

A $35 fee may be applied following a broken appointment with less than 48 hour notice. Rescheduling or cancelling with greater than 48 hour notice will not result in a broken appointment fee.

I grant my permission to you or your assignee to telephone me at my workplaces to discuss matters related to this form.

This agreement supercedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have read and agree to this financial policy. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Patient, parent or guardian Date Relationship to patient