



OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements 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 services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit and such collections received to the patient's account. However, this dental office cannot render on the assumption that out charges will be paid in full by an insurance company.

A service charge of 1 1/2% per month (18% 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, or 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 waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder to collect monies owed by me. 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.

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

This agreement supersedes all prior agreement 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 arrangements or quality of care are null and void.

I authorize the dentist or his assignee 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 to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian

Date

Relationship to Patient