



Patient Name: _____

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 costs incurred in their care to remain viable. Therefore, 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.

DENTAL INSURANCE: 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 any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

CHARGES: A fee of **\$50.00** will be charged for appointments changed or cancelled without a 48 hour notice. We reserve the right to excuse patients from the practice after (2) rescheduled or cancelled appointments. A service charge of 5% per month on the unpaid balance will be assessed on all accounts exceeding thirty (30) days from the date of service. A \$30.00 fee will be charged on all returned checks or debits.

COLLECTION: In consideration for the professional services rendered to be rendered to me, or at my request, to my minor child by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered. I further agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. 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. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes 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 arrangements 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 in paper form to my insurance carrier or any related entities that require such information 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 hereby agree to abide by the conditions outlined herein.

X _____
Signature of, Parent or Guardian

Date

Print Patient's name