

OFFICE FINANCIAL PROCEDURES AND FEDERAL TRUTH-IN-LENDING STATEMENT

Patients who carry dental insurance agree to provide a copy of his/her dental insurance card to our office. As a courtesy to our patients, we will electronically bill to your dental insurance and agree to assign all benefits to our office. However, **this dental office cannot render services on the assumption that all dental procedures will be paid in full by any insurance. Our office does call to verify your dental benefits and has estimated your portion based on the information provided by your dental plan.** The estimated patient share is due at the time of the service. Unless prior arrangements have been made.

In consideration for the professional services rendered to myself or to my minor child, by the dentist, I agree to pay, therefore, the reasonable value of said services/treatment to the said dentist or his assignee at the time of said rendered services/treatment. I further agree that the reasonable value of said services shall be billed unless objected by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition, and I further agree to pay all collection and or attorney's fees, up to 40% to collect monies owed by me. I authorized the release of financially identifiable information concerning my account, including services billed, payments made, services rendered, dates of service and interest charges assessed etc., to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

A service charge of 12 % per annum (1% per month) on the unpaid balance will be assessed on all accounts exceeding ninety day (90) from the date of service/treatment unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for the dental care can only be extended for a period of six (6) months from the date of the patient examination and treatment plan.

I also agree to notify the office as soon as possible or prior to 24 hours of said scheduled appointments if I am unable able to keep said appointment. If I should fail or cancel less than the 24 hours I understand that a late cancellation or failed appointment fee will be assessed to my account. This is based on the length of the appointment time.

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

All dental emergency appointments, or dental services performed without prior financial arrangements must be paid for at the time or the services. All dental after hour treatments are subject to after hour's fee and will also be paid for at the time of the rendered services.

This agreement supersedes all prior agreements signed, including any and all mediation and/or arbitration agreements. I acknowledge that any prior mediation or 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 hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent or Guardian

Date

Relationship to Patient