OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

Financial arrangements must be made in advance. 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 at the time services are rendered.

Services paid in full at time of service by either cash or check will receive a 5% discount.

Patients with dental insurance are directly responsible for the cost of dental services whether the insurance pays part or none of the services. With each insurance plan having different pay schedules, exemptions, and restrictions, we can not be held responsible for what an insurance will or will not pay. We will do all we can in correctly submitting insurance claims to your insurance company provided we have been given the correct information by you.

A monthly service charge at a fixed rate of 2% per month of the unpaid balance as of the last day of each month will be assessed and added to the balance of all accounts exceeding sixty(60) days from the date of service unless previously written financial arrangements are made.

In consideration for the professional services rendered to me , (or at my request, to my minor child or ward) by the dentist or licensed employee, I agree to pay the fees charged for the dental services at the time of service, or within 15 days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay all reasonable attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account. I authorize the release of financially identifiable information concerning my account, including charges billed payments made, and interest charges assessed, to the dentist's collection agency or collection attorney should collection procedures be necessary.

I grant 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.

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.

APPOINTMENTS: Please give us the courtesy of a 24 hour notice if you are unable to keep your appointment. There may be a charge for a missed or canceled appointment.

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.

This agreement supersedes all prior agreements signed, concerning our office policy and financial policy.

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Signature of Patient, Parent or Guardian Date