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. This practice depends upon reimbursement from our patients for the cost 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 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/she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients and assist in making collections form insurance companies and will credit any such collections received to the patient's account. Therefore payment of the patient's portion of services rendered is required at the time of service.

A service charge of 11/2% per month (18% per annual) on the unpaid balance will be assessed on all accounts existing sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimated 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 or his assignee at the time said services are rendered, or within (5) days of billing if credit shall be extended. In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees and court costs. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made and interest charges assessed, ect. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant permission to you or your assignee to telephone me at home, cell phone, or at my work place to discuss matters related to this form. I also agree to let this office leave a message 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 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 either electronically, by facsimile or 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 or 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 both sides of 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