

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT AND RELEASE AGREEMENT

Dental treatment is an excellent investment in you and your family's health and wellbeing. We recognize that long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

- I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge.
- I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier.
- I authorize assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patients Initials _____

FINANCIAL RESPONSIBILITY

I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options.

CASH, PERSONAL AND BANK CHECKS, AS WELL AS ALL MAJOR CREDIT CARDS. Returned checks will be charged a \$35.00 NSF fee on the patient account.

AFFORDABLE MONTHLY PAYMENT PLANS (SUBJECT TO APPROVAL). These are outside financing arrangements specifically designed for dentistry and related specialties – with AFFORDABLE MONTHLY payments.

- **NO initial payment with INTEREST FREE OPTIONS**
- **Low, fixed rates ranging from 4.0% -12%**
- **NO prepayment penalty, terms up to 60 months**
- **Quick and easy application process with Same Day Approval**

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

CANCELED AND MISSED APPOINTMENTS

I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least twenty-four hours in advance so that another patient may use the time reserved for me. There is a \$50 per hour charge for missed appointments or late cancellations.

Our office reserves the right to require a deposit of 25% of the estimated patient portion when scheduling appointments for treatment with our doctors. Failure to pay the deposit could result in your appointment being forfeited.

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance for the services provided but your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate can be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment, and to the use of same by doctor in scientific papers or demonstrations. I certify I have read, or had read to me, the contents of this form and realize the risks and limitations involved.

Patient/Responsible Party Signature

Date

Practice Representative

Date