DR. ELIZABETH J. RESNICK, D.D.S., P.C.

Patient Information Statement

Billing Procedures:
To control bookkeeping and other clerical costs, payment is due at the time services are rendered. Monthly statements are not routinely sent out. When statements are sent out for balances under $100.00, or for any **past due amount,** there will be a $5.00 billing fee per statement to cover the cost incurred by our office.

Broken Appointments:
Each appointment time is reserved specifically for an individual patient. If you need to cancel Scaling and Root Planning or Crown appointments please give our office at least 72 hour notice, otherwise **you will be charged a $150.00 broken appointment fee.** Insurance companies **do not** pay broken appointment fees.
Please Initial _____

Insurance:
All insurance matters are between you and your carrier. As a health provider, we can not be responsible for deficiencies or problems with your policy. Such problems **must be resolved between you and your insurance carrier.** However, as a service to our patients, our clerical staff will be happy to assist you in filing insurance and obtaining reimbursements.

Cost Advanced:
Patients shall be responsible for the payment of any cost advanced on their behalf by Dr. Resnick which include, but are not limited to, the cost of producing copies of radiographs, patient records, postage, and charges for long distance phone calls. **There will be a $55.00 charge for returned checks.**

Patient Records:
All patient records, including but not limited to, radiographs, periodontal charting, prognosis and diagnostic reports, and patient histories are the property of Dr. Resnick. In the event the patient records need to be forwarded to another health care provider for any reason, copies of the originals will be sent.

PATIENT AGREEMENT

I have read the Patient Information Statement and, by my signature, I accept financial responsibility for the services rendered to me and agree to pay any billing fees, broken appointment fees, or other cost incurred within the guidelines specified in this document. In addition, I agree to pay interest on past due balances at the rate of 21% per annum (1.8% per month) and to pay all costs of collection, including but not limited to court cost, collection fees, interest, and attorney's fees equal to 33 1/3% of the balance past due at the time the matter is referred for collection.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____