OFFICE FINANCIAL POLICIES AND TRUTH-IN-LENDING STATEMENT

Patients who have dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. **Each patient must be aware of their individual coverage and make sure prior to their visit that services will be covered**. Our office will submit claims to insurance companies and assist patients in determining benefits and eligibility; however the information obtained by our office does **not** guarantee coverage. Patients must understand that dental insurance is a contract between the patient and the insurance company and that the patient is the responsible party regarding dental fees.

For patients without dental coverage, payment in full is expected at time of service. Payment of co-pays, deductibles, and estimated patient portions are also due at time of service.

A monthly service charge of 1.5% per month of unpaid balances will be assessed and added to the balance of accounts exceeding sixty (60) days from the date of service unless other financial arrangements have been made.

In consideration for the professional services rendered to me, (or at my request, to my child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist. In the event my account becomes delinquent I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom the account has been turned over, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, charges, statements, and interest charges to the dentist's collection agency and attorney should it be necessary.

I authorize the dentist to release financially identifiable information and treatment information to my insurance company.

I acknowledge that I have read the above statement and agree to abide by the conditions outlined herein.

Signature of patient, parent or guardian