Agreement For:

Payment of Fees | Assignment of Insurance Benefits | Collection Fee | Attorneys' Fees | Interest | Consent for Treatment | Authorizations

SOUTH MILWAUKEE
FAMILY DENTAL
MICHAEL K SHINNERS, DDS,SC

PAYMENT OF FEES/ASSIGNMENT OF INSURANCE BENEFITS

I understand that I am financially responsible to Michael K. Shinners, D.D.S, for all fees for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer (including the difference between the amount paid by a patient's pre-approved "pre-treatment" plan and the fees charged by this office). I hereby authorize and assign payment to be made directly to Michael K. Shinners, D.D.S. for insurance benefits payable to me. This assignment of benefits shall be deemed ongoing until my insurance carrier receives written notice from me that I have revoked this assignment. The office of Michael K. Shinners, D.D.S. will submit a computer generated and/or "o-claim" claim form to my insurance company. I agree to be responsible for the fees charged to complete any claim forms other than this office's computer-generated A.D.A dental claim form. Patients are expected to give at least 24-hour advance notification of appointment cancellation. Broken appointments are subject to a cancellation fee.

It is agreed that Michael K. Shinners, D.D.S. will continue to treat the patient as long as payment is made pursuant to this agreement. In the event payment is not made when due, or in the event of a discharge in bankruptcy, Michael K. Shinners, D.D.S. has the right to place the patient in a maintenance status and terminate further treatment.

COLLECTION FEE/ATTORNEYS' FEES/INTEREST

I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee. I am also responsible for any reasonable attorneys' fees incurred to collect the fees, and I am responsible for interest at the rate of 1- ½% per month on the overdue balance, together with all costs incurred for collection of the amounts due and owing.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Michael K. Shinners, D.D.S. to release any information required in the processing of applications for insurance coverage for services rendered. This authorization provides for the release of objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (I am aware that there is a potential that the patient health information described pursuant to this authorization may be subject to redisclosure of the recipient and will no longer be protected by the Health Insurance Portability and accountability out of (HIPAA).

I understand that I have a right to revoke this authorization at any time and may do so by submitting my revocation in writing, to this office. I understand that my revocation will not apply to information that has already been released in response to this authorization. I understand that this authorization is voluntary, and I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment.

CONSENT FOR TREATMENT

I hereby consent to treatment provided by Michael K. Shinners D.D.S, its practitioners, employees or designees and authorize medical and surgical services, diagnostic procedures, anesthetics, and medications as deemed necessary or advisable by the practitioners providing treatment.

PATIENT ACKNOWLEDGMENT

I have read this Agreement and Authorization form and I understand its contents, and I have read and fully understand the office policies and procedures of Michael K. Shinners, D.D.S. I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of this form and that any verbal statements may not alter the contents of this form. My signature confirms that I fully accept and acknowledge each section of this form.

____________________	____________________	____________________
Witness Signature	Patient's Signature	Date