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 costs 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 dental services performed without previous financial arrangements, must be paid for in full 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 or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 1/2% per month (18%per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient exam. Accounts that are over 90 days are considered past due and will be subject to a monthly rebilling fee of $10.00.

In consideration for the professional services to be rendered to me, (or, at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining account balance plus the sum of the collection fee (up to 40%) charged by the collection agency to whom a delinquent account is turned in for collection, 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, including charges billed, payments made, and interest charges assessed, ect., to the dentist's collection agency or attorney should collection procedures become necessary. I also understand that if my account becomes delinquent that any discounts (ie: coupons,flyers,no insurance,or specials)given by the doctor will be removed and I will be responsible for the full value of said services provided.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or account information on my answering machine or with a family member.

I understand that appointments scheduled for myself, a minor child or ward that are not kept or canceled with 24 hours notice will be charged $35.00 for each appointment/hour scheduled.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, or facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I authorize assignment or payment of all dental benefits to which I or other family members are entitled, to be payable to Wendover Dental Care.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I acknowledge that I have received a copy of 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.
List names here:____

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge.
I agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian	**Date**	**Relationship to patient**

(Rev.4/10)