



**OFFICE FINANCIAL AND FEDERAL TRUTH-IN-LENDING STATEMENT**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and 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 cash 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. In consideration for the professional services rendered to me, (or at my request for 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. All delinquent accounts will be charged interest at the rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In the event legal action becomes necessary to collect the unpaid balance, the undersigned further agrees to pay all reasonable attorney's fees and court costs. 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 allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

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 authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

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.

I, <<patient\_first\_name>> <<patient\_last\_name>>, certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent, or guardian    Date <<current\_date>>    Relationship to Patient  
(Rev. 1/11