LOGAN RIDGE
DENTAL

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. The 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 at the time services are rendered.

Patients that carry dental insurance understand that all dental services not paid by the insurance company within sixty days are charged directly to the patient and are 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 1.½% per month (18% per annum) of the unpaid balance will be added monthly on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are made. I understand that the fee estimated listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

We realize that unforeseen problems do come at the last moment. Therefore, we will not charge a fee for missed appointments. We do ask that you be courteous to other patients and our staff by giving us 24 hours prior notice if you need to change or cancel an appointment.

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 said services are rendered, or within five (5) days of billing if credit is extended by the dentist. I understand that if I do not keep this arrangement and I default on my agreement, this account will be placed with a collection agency where I will be responsible for any court costs, all attorney fees, filing fees, late charges, finance charges including charges of commissions of 40% that may be assed to us by a collection agency retained to pursue this matter, with or without suit, and interest at ___% per annum. 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 as described become necessary.

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

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 results on my answering machine or with family member.

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 hereby agree to abide by the conditions outlined hereon.

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Signature of patient, parent or guardian date relationship to patient

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Insurance Responsibilities and Estimates

Please note that **ALL quotes and prices are estimates** when insurance is factored in. Co-payments are due at the time of service.

It is the responsibility of the patient to know his/her individual insurance coverage and follow through with his/her insurance company to see that payments are made. Also be aware of your renewal dates of coverage and yearly max benefits.

The front office staff is providing a service for you in inquiring about your coverage and is striving to give you the most accurate amount. We cannot guarantee that the services will be covered according to the information we have been given. All rendered procedures that are not covered by insurance are the patient's responsibility.

I understand that I am solely responsible for the full payment of services received from Dr. Blake Cameron on **ANY and ALL** procedures that are uncovered and/or denied by my insurance company.

By Signing I agree to pay for all services in full received from Dr. Blake Cameron in accordance with "Office Financial Policies and Federal Truth-In-Lending Statement" that are denied and/or otherwise not covered by my insurance company.

Patient Signature _____Date _____

Witness_____