

Truth In Lending Statement/ Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid at the time services are rendered.

Patients who carry dental insurance must understand that all services 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 patients insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office can not render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month(18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time that payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and your assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment, and I agree to their content.

Signature of
Guarantor:

Print Name:

Date:

Relationship to Patient:

Self

Spouse

Parent

Guardian