FINANCIAL RESPONSIBILITY CONTRACT

In agreeing to be responsible for your dental care, ***JUNCTION CREEK FAMILY DENTISTRY/JOHN C. HENING, D.D.S./John C. Hening, D.D.S.***, requires that you be responsible for your *financial obligation* to us.

Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf.

1. I agree to pay for all services provided to me by *JUNCTION CREEK FAMILY DENTISTRY/JOHN C. HENING, D.D.S.* at the time services are rendered, unless those services are covered by my insurance company.

2. I understand that my insurance company may require that I pay co-payments, co-insurance and/or deductibles. I agree to pay these in full at the time services are rendered.

3. I understand and agree that if, upon 45 days of billing and/or insurance is filed, my contracted insurance has not paid the office of *JUNCTION CREEK FAMILY DENTISTRY/JOHN C. HENING, D.D.S., I may also be required to contact my insurance company myself to ask for resolution of the unpaid claim(s).*

4. I understand and agree that if, after 45 days of billing, whether my non-contracted insurance company has made a payment or not on my account, I am responsible for the total balance due on that account.

5. I understand and agree that if a balance on my account remains unpaid after 45 days, that account maybe sent to a collection agency. I will then be responsible for any amount due plus cost of collection, including, but not limited to:

   - All collection expenses charged by the collection agency;
   - Court costs;
   - Attorneys' fees; and
   - Any discounts I may have received on my account will be reversed.

6. If my account is sent to a collection agency, *JUNCTION CREEK FAMILY DENTISTRY/JOHN C. HENING, D.D.S.* may require me to permanently seek further dental care elsewhere.