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**. Our office offers several payment options to fit your personal needs. This practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable therefore, **payment is expected at time of service or when scheduling appointments depending on the dental treatment needed.** We reserve the right to make changes if needed.

EMERGENCY 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.

INSURANCE

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. As a courtesy we will help prepare and file the insurance form for patients and will credit any such collections received to the patient's account. However, **this office cannot render services on the assumption that our charges will be paid in full by an insurance company**.

DELINQUENT ACCOUNTS

A service charge of 1.5% per month will be added to the unpaid balance and will be assessed on all accounts exceeding sixty (60) days from the date of service.

In consideration for the professional services to be rendered by Dr Paul Hanna, DDS to me, or to my minor children or any children I have been appointed guardian of, **I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time services are rendered, or within five (5) days of billing.**

I agree to pay the remaining balance plus any costs incurred by collection agencies, court costs, or any reasonable attorney fee should my account become delinquent & therefore is assigned to a collection agency or an attorney. **I authorize COLLECTION FEES to be added to my account, as described above, and the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary**.

I grant my permission to you and 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.

MISSED APPOINTMENTS

Missed appointments or less than 2 business days' notice for any changes/cancellations of your appointment will incur a $35 fee at the Doctor's discretion.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation / arbitration agreements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information or treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information 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 CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS ON BOTH PAGES OF THIS FORM ACCURATELY AND TO THE BEST OF MY KNOWLEDGE. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREIN.

Signature: _____ Date: _____

Witness: _____ Date: _____