BENCHMARK DENTAL
OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT
Please Read & Sign

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the estimated portion not covered by insurance) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for 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 that 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) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

If an appointment is canceled or missed with less than 24 hours notice, a no show fee will be charged to your account at $50.00 for every ½ hour scheduled. This time is reserved for you specifically and in order to keep our costs low, we need to have 24 hour notice.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or his/her signee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to which a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize 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 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 signed agreements, 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/her 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.

Next Page>

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 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

Relationship to Patient_____