Notice of 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 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 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. If we do not receive payment from your insurance company within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A service charge of 1.5% per month (18% APR) on the unpaid balance may be assessed on all accounts exceeding thirty (30) days from the date of service unless previously written financial arrangements are made. There is a $5 late payment fee. 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. A fee of $46 per scheduled appointment hour is charged for patients who miss or cancel more than once without 24-hour notice. There is a fee of $25 for returned checks.

In consideration for the professional services to be rendered to me (or at my request, to my minor child or ward) by Freedom Dental Care, LLC, I agree to pay the fees charged for the dental services provided by the Dentist or licensed employee at the time the services are rendered, or within ten (10) 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 turned 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 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 let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, 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 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 also authorize payment directly to Julia Burchett, DDS of the Group insurance benefits otherwise payable to me.

I have read and hereby agree to abide by the conditions outlined herein.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Relationship to Patient: _____