SIMPLY GREAT DENTISTRY

SUMMIT

FAMILY DENTAL

Financial Policy

I, the patient, parent, or guardian (responsible party) of the patient, will be responsible for any balance on this account. Insurance will be billed, if available, but I am responsible for any balance remaining after contracted or non-contracted insurance payment or denial, this includes any services that are not a covered benefit. If there is no insurance to bill, I understand that I am responsible for this account and will make payment arrangements before receiving treatment. I understand that this account will be considered delinquent if payment is not received within 60 days from the date of service. Delinquent accounts will be sent to a collection agency. A collection fee of 50% of the balance due will be added to your account plus any attorney fees. If the balance is deemed non-collectible by the collection agency after 30 days, a report will be filed with the three national credit reporting agencies, which will adversely affect your credit rating. I also understand that any check returned to Sundance Dental Care will result in my account being charged a $50.00 fee. Summit Family Dental reserves the right to contact the district attorney's office and seek legal redress if attempts to remedy the situation are not made in a timely manner. My signature below indicates that I authorize Summit Family Dental with my permission to release my information in the event a collection agency or the district attorney's office has to be involved.

Appointments and Cancellation Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give at least a 48 hour notice. There is a charge of $50.00 for not showing up for scheduled appointments. In addition, repeated cancellations or missed appointments will result in loss of future appointment privileges and discharge of the patient.

Consent for Services

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including use of local anesthetics as indicated and I will assume responsibility for the fees associated with those procedures. I am aware that payment is required on the day services are rendered and have been informed of Summit Family Dental's Financial Policy and Appointment and Cancellation Policy.

I acknowledge that I have read and understand the above policies and conditions of treatment and payment and agree to the content.

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Signature of Patient, Parent or Responsible Party Date