Financial Policy

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This is an agreement between the aforementioned Drs., as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you, "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the two aforementioned Drs.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if applicable, and any payments or credits applied to your account during the month.

Payments: **Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.**

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of services.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment option if you have Insurance:

1. You choose to pay your deductible of $____and any out-of-pocket portions at the time services are rendered by __cash, __check, or credit card.
2. On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date.

Payment options if you have No Insurance:

1. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving laboratory procedures (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance on the completion or delivery date.
3. We offer special financing through ***Care Credit.*** If you pay them within 6 months or 12 months, there will be no interest charges.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the first determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charges: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a half percent (1 ½ %) per month of an annual percentage rate of eighteen (18%) percent.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. **If we have to refer your account to a collection agency, you agree to pay all cost of collection, attorney's fees and court costs incurred in the collection of your account.** In case of suit, you agree the venue shall be in Shelby County, Tennessee.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank.

Missed Appointments: The second time a patient does not show up for a schedule appointment, a $50.00 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor. We understand that emergencies do happen, however, we ask that you please consider our time as we feel we consider yours.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: ____

Responsible Party
(If not the patient):____

Signature: ____________________________________Date:____________

(Revised 5/11/10)