FINANCIAL POLICY

Premiere Dentistry of Tahlequah
1205 E. Ross By-Pass
Tahlequah, OK 74464
(918) 456-2555 Telephone
(918) 456-2444 Fax

Dr. Mark D. Smith
Dr. R. Stephen Jones

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

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

_____ (initials) **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 any, and any payments or credits applied to your account during the month.

_____ (initials) **Payment Options: ALL PAYMENTS ARE DUE ON THE DAY SERVICES ARE RENDERED.** If you have insurance, we require that you deductible and your percentage be paid at the time of service.

A. You choose to pay by (1) Cash, (2) Check, or (3) Credit Card (No American Express)
B. **WE CANNOT SET UP PAYMENT PLANS THROUGH OUR OFFICE.** However, we do have financing available through Care Credit. If you are unable to pay in full on the date services are rendered and need to make financing arrangements, you MUST notify the receptionist prior to being seen so the appropriate paperwork can be filled out.

_____ **(**initials) **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 and secondary insurances as a courtesy to you. Although we may estimate what your insurance company may pay, it is merely an estimate and not a guarantee of payment, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. It is also your responsibility to keep track of any annual insurance maximums. Claims are submitted promptly after treatment is rendered and if not paid by your insurance company buy the 61st day after treatment, you will be billed and a finance charge will be charged on the balance remaining.

_____ (initials) **Finance Charges:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

_____ (initials) **Returned Checks:** There is a fee (currently $30.00) for any checks returned by the bank.

(TURN OVER)

_____ (initials) **Missed Appointments:** Patients with three (3) missed appointments will be asked to transfer their records to another Dentist. A missed appointment is defined as an appointment in which the patient does not show up or an appointment which is cancelled with less than 24 hours notice.

_____ (initials) **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 of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cherokee County, Oklahoma.

_____ (initials) **Divorced or Unmarried Parents:** The parent authorizing treatment for a child will be the party primarily responsible for those charges. If the divorce decree or other order 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. Monthly statements will only be sent to the authorizing parent. **The "authorizing parent" is the party signing this financial policy.** This policy is not a waiver of any rights concerning the collection of this debt from either parent.

_____ (initials) **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.

_____ (initials) **Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee 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.

_____ (initials) **Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. We cannot bill your attorney or other party for charges incurred due to a personal injury case.

_____ (initials) **Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect for all subsequent charges.

Patient's Name:
_____

If Patient is a Minor, Parent's Name:
_____

Signature: _____ Date: _____/_____/_____