FINANCIAL POLICIES

In accordance with the Federal Truth-in-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to our office:

1. The patient agrees to pay the doctor at the time that services are rendered or by previous arrangement.

2. Balances left unpaid beyond 60 days will be assessed a finance charge of 1 ½% per month (annual rate of 18% per year) with a minimum charge of $1.00 per month. Interest not paid when due shall be added to and become part of the principal.

3. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

4. There will be a $20.00 charge assessed on all returned checks.

5. Personal and joint credit may be checked.

I CERTIFY THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE ABOVE POLICIES

_____ _____

Signature **Date**

INSURANCE FACTS

1. Professional services are rendered to the patient and not to the insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. We are more than happy to help you by submitting your dental claims without any charge. Unfortunately, insurance benefits can be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company. We are unable to increase benefits beyond that agreement.

3. For your convenience we will **estimate** the portion of your total fee that your insurance company will cover. This is **just an estimate**. After insurance benefits, you are responsible for any unpaid balance. We will ask you to cover the cost of the treatment that insurance company does not cover at the time that services are rendered.

I certify that I am covered by_____Insurance Company, and I assign directly to Dr. Jeffrey F. Ward all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying my deductible and any co-payment that my insurance does not cover. I hereby authorize Dr. Ward to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

_____ _____

Signature **Date**