Office Financial Policies

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement form our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged to their dental insurance. The patient is responsible for paying the estimated co-payment at each dental appointment. This office will help prepare the insurance forms of our patients and 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 service on the assumption that our charges will be paid in full by an insurance company. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service, unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I agree to pay the fees charged for the dental services provided to the dentist of his/her assignee at the time the services are rendered. I further agree to pay the remaining balance plus reasonable attorney fees, court costs, and a collection agency fee of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. 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 collection 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.

I authorize the dentist and his assignees to release financial 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 acknowledge that I have read a copy of this office's privacy policies. I agree to disclose to the dentist names of any individuals whom I authorize the dentist to discuss my dental care.

•Pony Express Dental reserves the right to charge a $50.00 fee for any appointment cancelled without 48 hours notice and a $25.00 fee for any returned checks.

•I acknowledge that treatment plans are ESTIMATES ONLY and are based on information given by my insurance company and me. All treatment costs remain my responsibility and I promise to pay my account, regardless of insurance coverage.

If patient is 15 minutes late to his/her appointment, then appointment may have to be rescheduled.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

______________________________	____________	____________________________
Signature of patient, parent, or guardian	Date	Relationship to patient