1. Release of Information

I authorize PROSPECT DENTAL to release any information to insurance carriers and/or other health care providers as may be necessary to file claim or facilitate my dental care. I assign payment of benefits to PROSPECT DENTAL or provider indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this authorization is valid as the original.

_________________________________ SIGNATURE

_________________________________ DATE

2. Patient's Financial Policy

The objective of our financial policy is to clearly outline patient and practice responsibilities. We are committed to providing our patients with excellent care and to make matters related to the payment for dental care services as straightforward as possible.

- Our office will submit claims to dental insurance carriers (if insurance carrier will not submit payment to our office within 90 days, patient becomes responsible for remaining balance).
- It is your responsibility to provide us with accurate and current insurance information.
- You are required to pay deductible and to pay co-payments at the time of service. If you do not have insurance, you are expected to pay for professional services at the time of service.
- Our office will send to your insurance carrier the pre-determination of benefits for services, which require such pre-determination. Based on their written approval you will be responsible for required co-payment, OR in case of denial of particular service you will be responsible for the full fee if you decide to proceed with the treatment. You are financially responsible for any service not covered by your insurance carrier.
- For all procedures that require lab work (crowns, bridges, dentures, posts, night guards, etc.) a 50% down payment is required before the impressions can be sent to the lab. If you have dental insurance, then your co-payment is required at that time.
- There is $30 returned check fee should the check be returned to us by the Bank due to insufficient funds or stop payments.
- We reserve the right to charge $50 broken appointment fee if you fail to give us a 24hrs notice to cancel/reschedule your appointment or do not show for an appointment. I authorize a charge/ payment on my credit card.
- Payment for services can be made with cash, check or credit card. We accept MasterCard, Visa and Discover.
- I understand that I am ultimately responsible for full payment and agree to pay $10 per month billing charge and 10% compounded monthly interest for all unpaid balances at least 90 days overdue. If necessary, I voluntarily agree to a wage garnishment and understand that I am responsible of all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt.

I understand and agree that health and accident insurance policies are only an agreement between the insurance carrier and me. Only my insurance company can address specific questions about my coverage.

Please sign that you have read and agree to this financial policy:

_________________________________ SIGNATURE

_________________________________ DATE

_________________________________ SIGNATURE(WITNESS)

_________________________________ DATE