Patient Financial Agreement

Dear Patient,

This letter sets forth our office financial policy.

I understand that as a recipient of dental care I, the undersigned, am responsible for all charged regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate the doctor for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for services provided, notwithstanding any contract may have with any third party payer (for example, insurance company, employer, etc.).

The undersigned herby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor and all necessary parties to submit claims and obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Douglas J. Brajcich DMD or Julie Lum DMD all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill.

Payment may be made with cash, check, or credit card (Visa and Mastercard). There is a $30.00 service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing this office with complete and accurate billing information, including, but not limited to, a current insurance card and authorization numbers. I am responsible for all visits and procedures not properly authorized.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit unless otherwise arranged with the doctor.
3. I understand that I may be charged $77.00 if I fail an appointment or if I cancel without at least 24 hours notification.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (patient or guardian)_____DATE_____
FOR (print patient's name) _____