OFFICE FINANCIAL POLICY

Date: **Office:** **Patient:**

We are happy you have chosen Professional Dental as your dental provider. We accept many different insurances to benefit our patients. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs 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 it is their responsibility to provide correct/updated insurance information. All dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services. Professional Dental is happy to submit insurance forms and help resolve outstanding claims to the insurance company designated by you. You must understand that not all insurance companies pay in full for estimated services rendered. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Professional Dental or anyone acting on its behalf. I understand and agree that such calls may be initiated by Professional Dental or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

I agree that if payment cannot be made at the time of service, treatment may be denied and I am responsible for any costs incurred. I agree that any verbal agreement for payment is a legal agreement and I will be held to such agreements until the balance of my account is paid off.

I understand that there will be $25 charge on all returned checks. I understand that after one check is returned, the only method of payment this office can accept is cash or credit. I understand that 24-48 hours notice is required to cancel an appointment. In order to keep costs low, I agree that I must be at each appointment as agreed and scheduled. A minimum of a $60 charge will be made for broken or failed appointments.

I accept Professional Dental’s Office Financial Policy:

Signature	Full Name	Relation to patient	Date