

## Office Financial Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements **must be made in advance**. The viability of this practice depends upon reimbursement from our patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

1. I understand that all emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash or credit at the time services are rendered.	_____ Initials
2. I understand that payment is required when services are rendered.	_____ Initials
3. I understand that if I have dental insurance, my estimated co-pay for dental service is expected when services are rendered.	_____ Initials
4. <b>I understand that I AM RESPONSIBLE for knowing my insurance plan as well as the benefits paid under my plan. It is my responsibility to know my insurance policy and I take full responsibility to pay fees not covered by my plan. (As a courtesy our office will assist in preparing insurance forms; however, we cannot render services on the assumption that our charges will be paid in full by an insurance company.)</b>	_____ Initials
5. I understand that procedures requiring multiple appointments may be paid over time for example: <ul style="list-style-type: none"> <li>• Crowns                    ½ down on initial visit                                   Balance due on delivery of crown</li> <li>• Bridgework                ½ down on initial visit                                   Balance due on delivery of bridge</li> </ul>	_____ Initials
6. I understand that a finance charge of 1.5% per month (18.00 per annum) will be added to any outstanding amount on my account that is more than 60 days past due. I will be responsible for payment of any legal, attorney, and court fees as well as collection commission costs up to 50% of the total bill plus the remaining balance, if these services become required in order to collect my outstanding balance.	_____ Initials
7. 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.	_____ Initials
8. I authorize assignment or payment of all dental and/or surgical benefits to which other family members or I are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Steven P. Sachs.	_____ Initials
9. I understand that appointments NOT CANCELLED 24 HOURS IN ADVANCE will result in a \$30 charge, and that MY INSURANCE COMPANY WILL NOT PAY FOR THOSE FEES. I further understand that I will be billed for all missed appointments and that my insurance company will not pay for those missed appointments.	_____ Initials
10. <b>I _____, give my permission for Sachs Family Dental to discuss my financial account and treatment plan with the following people: _____</b>	_____ Initials

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

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date