

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to Dr. Ronnie L. Hold, Jr. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**MINOR/CHILD CONSENT & FINANCIAL AGREEMENT**

I, being the parent or guardian of \_\_\_\_\_, do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration on anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I acknowledge that the payment is due at the time of the treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment or minor/child. I accept full financial responsibility for all charges not covered by insurance

Date \_\_\_\_\_ Signature \_\_\_\_\_

**GENERAL**

Payment for dental care is due and payable at the time the care is rendered, i.e., at the completion of the dental visit, unless other arrangements such as payments and/or insurance are discussed and agreed to **in advance**. Payment in full at the completion of the dental visit will, in the long run, reduce the cost of your care, as it will reduce our bookkeeping, billing, and collection costs.

**INSURANCE**

Insurance is a benefit provided to employees to assist them in obtaining proper healthcare as needed. Dental plans usually **do not** pay the entire cost of the care, although the often pay most or all of the costs of preventive visits. Insurance benefits are actually owed to the **insured** (employee), not the dentist. For your convenience, we may allow your insurance payment to be sent directly here, to be applied to your account. Please note that any benefit that we might estimate prior to filing an insurance claim is **not** a guaranteed payment, as insurance companies often do as they please, with no valid explanation. **Patients** are responsible for any unpaid balance not promptly paid for by their insurance.

**STATEMENTS**

Even if an insurance claim is outstanding, your statement will show the total amount owed on your account. Unpaid amounts, or at least the estimated co-payment should be paid by the **10<sup>th</sup>** of the month following the statement. Statements will show the aged balances. **FINANCE CHARGES OF 1.5% PER MONTH (18% APR) WILL BE COMPUTED ON ALL BALANCES SHOWN TO BE OLDER THAN 60 DAYS.** This applies even to accounts that have a payment agreement. We believe this is a fair policy, as it allows a generous grace period, free of any finance charge. **The MINIMUM FINANCE CHARGE TO BE APPLIED TO SUCH ACCOUNTS IS \$1.50.**

**DELIQUENT ACCOUNTS**

Accounts with a balance older than 90 days, toward which there has been no or insufficient payment, will be considered delinquent, and may be subject to collection by means of a **COLLECTION AGENCY, CIVIL SUIT, OR BOTH.** In such cases, the patient debtor shall bear all collection costs, including, but not limited to, attorney fees and court costs.

Finance charge of **18% APR** will apply to collection costs and court costs from the date they are incurred and posted to the patient's account. Finance charges will continue to accrue until the entire balance of all charges, including finance and collection charges, is paid in full. Additionally, the grace period will not be recognized and finance charges will be computed as being from the date of treatment.

**OTHER**

There will be a \$35 charge on all returned checks.

**FINANCIAL AGREEMENT**

I accept full financial responsibility for all charges not covered by insurance. I authorize the dental staff to perform all necessary dental services on myself including but not limited to x-rays.



Date

Signature