BRIGHAM City Smiles
DR. MARK MURDOCK
DR. PJ SUTTON

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 practice depends upon 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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patients and that he or she is personally responsible for payments for all dental services. As a courtesy this office will submit insurance forms. However, this dental office cannot render services on the assumption that our changes will be paid in full by an insurance company.

As a courtesy to you, you will be provided with an estimated breakdown of what your portion may be and what the insurance portion may be. Should your insurance not pay the full amount estimated, you are responsible for the balance in full.

A service charge of $25.00 per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 30 days from the date of service unless previously written financial agreement are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Should collections become necessary, I understand that I am to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney's fee and all court fees. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interests charges assessed, etc. to the dentists collection agency or collection attorney should collection procedures as described become necessary.

Should the child have two responsible parties, namely the mother and father, who are divorced, I understand that this office does not bill both parties. I understand that I will pay the account balance in full and will be responsible on my own to collect from the second party. This office does not make financial arrangements with any other responsible party other then myself.

I understand that when I make a dental appointment that it is my responsibility to call should I need to change or cancel the appointment. I understand that should I miss my dental appointment *without* a 24 hours advance courtesy call made, then I will be charged a fee up to $150.

I grant permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/ arbitration agreements signed previously related to financial agreements or quality of care or null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information's, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that requires such information can be submitted.

I hereby agree to abide by the conditions outlined herein.

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Signature of Patient, Parent or Guardian **Relationship to patient**