QC SOUTH DENTISTRY FINANCIAL POLICY

ASSIGNMENT AND RELEASE FOR INSURANCE BENEFITS If I the undersigned have or get insurance, I assign directly QC South Dentistry 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.

PATIENT AGREEMENT AND FINANCIAL POLICY I hereby agree to be responsible for the costs of care provided by QC South Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy. Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand personal checks will not be accepted at QC South Dentistry

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 HOURS prior to my scheduled appointment time. For appointments scheduled with the doctor for restorative work, a cancellation fee of $100 per hour scheduled may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time. For appointments scheduled for hygiene, a cancellation fee of $50 per hour scheduled may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments

are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

IN THE CASE OF A MINOR: I, being the parent or legal guardian of the legal guardian named above, do here by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

I understand the above information and agree with its contents.

Signature

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