

Agreement
Financial Responsibility for Treatment
(Read, then sign & date on page 2)

Condition of Treatment: Financial arrangements must be made in advance of treatment. The patient's/guarantor's responsibility must be determined before treatment.

Emergency Care: All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for, by cash, debit, or credit card, at the time services are performed.

Consideration for Professional Services: In consideration for the professional services rendered, the undersigned agrees to pay for the predetermined value of said services to Dr. Jim Dick, or his assignee(s), at the time said services are rendered.

Financial Agreement: The undersigned agrees, whether he or she signs as patient, as patient's parent, legal guardian, or as the patient's agent or representative, that in consideration for the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account owed by the patient.

Benefits for Dental Care: This office, as a courtesy, will help prepare the patient's insurance forms, and assist in making collections from the insurance companies and will credit such collections to the patient's account. The person designated as the responsible party agrees to be responsible for all charges for dental services and materials not paid by the dental benefits plan, unless Dr. Dick has a contractual agreement with the plan prohibiting all or a portion of such charges. Currently, Dr. Dick is not under contract with any insurance carrier. To the extent permitted under applicable law, the undersigned authorizes release of any information relating to the claim. Further, authorization of release of any information relating to the dental insurance is given. I, the undersigned, understand that I am responsible for the costs of dental treatment. I hereby authorize payment of dental benefits, otherwise payable directly to me, directly to Jim Dick, DDS, of 3974 Norcross Road, Chattanooga, TN 37415.

Payment Upon Receipt of Bill: I, the undersigned, guarantee that said bill will be paid upon receipt and the balance of said bill will be paid prior to discharge of said patient.

Service Charge: The undersigned agrees, whether he or she signs as patient, as patient's parent or legal guardian, or as patient's agent or representative, that a service charge of 1½% per month (18% per annum) on the unpaid balance on all accounts exceeding 90 days past due, unless previous written financial arrangements have been satisfied, will be assessed against the patient's account.

Referral to Collection Agency or Attorney for Collection: Should the account be referred for collection, the undersigned shall pay reasonable attorney fees and/or collection agency fees, and the other costs of collection, including court costs. The undersigned authorizes the transfer of any overpayment on this account to be applied to any accounts on which the undersigned is patient, guarantor, or otherwise legally responsible. The undersigned agrees that the reasonable value of said services shall be as billed unless objected to, in writing, within the time for payment thereof. The undersigned agrees that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and agrees to pay all costs and reasonable attorney fees if suit is instituted hereunder.

Authorization to Contact Me: I, the undersigned, grant permission to the office of Jim Dick, DDS, and/or their assignee(s), to telephone me at home, at work or on my cell phone, or to email me to discuss matters related to this form.

Credit Report: I, the undersigned, authorize the office of Jim Dick, DDS, and/or his assignee(s), to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Checks are Accepted Only for Established Patients Under the Following Conditions: In the event of a returned check, attempts will be made to redeposit the original check, when feasible. When payment is made by check, you expressly authorize this merchant, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a returned-check processing fee of \$20.00 (or the maximum allowed by state law). Use of a check for payment is your acknowledgement and acceptance of this policy and its terms.

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Records Release (Non Workers' Compensation): A minimum of 48 hours advance notice (2 business days from the date and time of request) is required for all records requests. Records include photoduplicates of digital x-rays. An administrative fee of \$3.00, per photoduplicate, for x-ray(s), and \$10.00 for other patient records, will be assessed against the patient's account, not to exceed a total cost of \$20.00. This represents the actual costs for labor and materials (Exception: This fee will not be charged in the event that Dr. Dick has referred a patient to a specialist for treatment and/or evaluation).

Appointment Policy: We respectfully request that you provide a minimum of 48 hours notification, if an appointment must be missed and rescheduled. The first time you miss an appointment, without adequate prior notice, it will simply be documented. The second occurrence will result in a \$50 "broken appointment" administrative expense fee, assessed against your account.

Senior Discount: Patients age 60 years or greater are entitled to a 5% senior discount off the total cost of their treatment (if you qualify, please remind the Patient Services Coordinator when you check out at the Reception Desk).*

*Only one discount offer may be used at a time.

This applies to the Senior Discount and any coupon or promotional discount offer.

I, the undersigned (guarantor / responsible party for this account), have read the above conditions of treatment and agree to their content. I hereby agree that I will guarantee the payment of the bill.

PRINT PATIENT'S NAME:

First	Last	MI
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SIGNATURE OF GUARANTOR:

	Date
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PRINT NAME OF GUARANTOR (if Different from Patient, i.e., Parent / Legal Guardian / Other):

First	Last	MI
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