FINANCIAL AGREEMENT AND CONSENT

This agreement is to inform the Patient/Guardian of your financial obligation to Dr. Elizabeth K. Schmahl. By executing this agreement, you are agreeing to pay for all services that are received. We believe that you deserve the highest quality of dental care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits and some do not.

Initial (Patients with Insurance)

______ If you **have dental benefits**, your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is **due at the time** service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. You may direct your insurance company to pay benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement.

______ **All charges you incur are your responsibility regardless of insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, not your insurance company even if we are Preferred Provider for that company. We work with numerous companies. We estimate your co-payment portion based on the most up-to-date information we have, but it is **only an estimate.** We are happy to file a "pre-determination of benefits" with your insurance company prior to treatment. However, predeterminations are not a guarantee of payment and they delay treatment.

______ We will bill your insurance as a courtesy. If your insurance does not pay within 45 days, we reserve the right to request payment in full for services from you and then have your insurance company reimburse you directly.

Initial (All Patients)

______ For **non-insured patients**, payment in full is required at the time of service. We accept MasterCard, Visa, Discover, American Express, cash and checks
______ There is a $25.00 fee for any checks returned by the bank.
______ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. We required **at least 24 hours notice** for any cancellation or reschedule. Otherwise, you will be charged **a $50 per hour "Late Cancel/No Show Fee"**.

Consent

I give this practice my consent to use or disclose my protected health information (i.e. Diagnosis and records of any services rendered to myself or my dependent) to carry out my treatment, and to obtain payment from insurance companies (third party payors) and/or Health Practitioners. I authorize my insurance company to pay directly to the Dentist, Insurance Benefits otherwise payable to me.

I have been offered a copy of this practice's Notice of Privacy Practices. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to a restriction of how my protected health information is used and I can make my request in writing. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already disclosed.

Any account past due (30 days) is subject to a $5.00 monthly fee. If your account is past due we will take necessary steps to collect this debt including forwarding the account to a collection agency. In the event, legal action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the courts. In the event this account is referred for collections, I/We agree to pay collection fees up to 50% on the balance submitted.

I certify that I have read and understand the above information to the best of my knowledge.

Signature______________________________ Print Name____________________________ Date_____________