OFFICE FINANCIAL & DISCLOSURE POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT
UTAH VALLEY ENDODONTICS
PAUL M. CREER, D.D.S.

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost 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 performed without previous financial arrangements must be paid in full at the time services are rendered. **Utah Valley Endodontics, charges a $50 Missed Appointment Fee for appointments broken or cancelled without two business days notice.**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she, not the insurance company, is personally responsible for payment of all dental services. Your insurance policy is a pre-determined arrangement between your employer and the insurance company. We are not a party to that contract. This office will help prepare and submit the insurance forms for our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. Any co-pay quoted from this office is an estimate only, not a guarantee of coverage. Unfortunately, insurance benefits will almost always be less than anticipated. It is **your responsibility** to contact your insurance to determine your particular benefits or requirements. **This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.**

· I authorize the dentist or his designees to release financially identifiable information, treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. After insurance payment is applied, I understand that should the balance be $5.00 or under, I will not be billed, or should the overpayment be $5.00 or under, I will not be refunded.

· A service charge of 1½ % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written finance arrangements are satisfied. 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. I also understand that I will be responsible for a $25 fee for any returned check.

· In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

· In the event that full payment for charges incurred in my dental care is not made, I agree to pay all costs of collection, including a Collection Agency Commission of up to 45% and interest rate of 18% per annum. I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder to collect monies owed by me. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency should collection procedures as described become necessary. I also agree to submit myself to the jurisdiction of the courts of Utah County, Utah. I understand that should my account be turned over to a collection agency, this office retains the right to refuse further services.

· I grant my permission to this office to telephone me at home or at my workplace to discuss matters related to this form or my treatment. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

· I acknowledge that I have received or declined a copy of the office's Privacy and Office Policies.

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

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

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Name of Patient (PLEASE PRINT)

______________________________ | ____________ | ____________________
Signature of Patient, Parent or Guardian | **Date** | **Relationship to Patient**