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. 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, or any dental services performed without previous financial arrangements, must be paid for in cash/check at the time of services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that charges will be paid in full by the insurance company.

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 the fee estimate is only that, AN ESTIMATE. The insurance company may provide benefits differently than estimated by the dental office.

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 services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the responsible value of said services shall be as billed unless objected by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter. 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 or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

This agreement supersedes all prior arrangements 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 arrangements or quality of care are null and void.

I authorize the dentist or his assignees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or ant related entities that require such information to be submitted. I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and the other group health plan benefits otherwise payable to the undersigned, to Dr. Haynie or Oquirrh Dental.

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 and outlined hereon.

Signature of patient, Parent or Guardian	Date	Relationship to patient