CONSENT FOR SERVICES / FINANCIAL POLICY

As a condition of your treatment, financial arrangements must be made in advance. The practice depends on reimbursement from the patient, or their legal guardian, for the fees incurred in their care. The person accepting financial responsibility for services rendered must be determined prior to the start of treatment.

The patient, or their legal guardian, is ultimately responsible for the payment for all fees incurred in their treatment, regardless of dental insurance coverage.

Fees for emergency dental services performed without verification of dental insurance coverage and benefits, or previous written financial arrangements, must be paid in full by cash or check at the time services are rendered.

This office will prepare and submit primary and secondary dental insurance claims on behalf of all patients. However, this office will only accept assignment of dental insurance benefits from a patient's primary insurance policy. Therefore, patient co-payments due at the time of service will be calculated, and collected, based on the *estimated* benefits anticipated from the patient's primary insurance policy only. Benefits payable by patient's secondary insurance policy will be paid to them directly by their insurance company.

This office will file all primary and secondary insurance claims in a timely manner and gladly assist patients in the collection of all insurance benefits due for services rendered. However, this office cannot render services on the assumption that charges will be paid, in part or whole, by an insurance company.

A finance charge of 1.5% per month (18% per annum) will be assessed on the unpaid balance of all accounts 60 days or more outstanding. Finance charges will be assessed, regardless of pending insurance claims, unless previous written financial arrangements have been made and all payments under such an agreement have been received by the payment date defined in the agreement.

Estimated fees for dental treatment can only be guaranteed for 60 days from the date of a patient's oral examination and diagnosis.

In consideration for the professional services rendered to me as determined by the doctor, or at my request, I agree to pay fees for such services to Susan M. King, D.M.D. and Associates, P.S.C. on the day said services are rendered, or within five (15) days of receipt of a billing statement, should my insurance policy pay less than the estimated benefits.

I understand that my treatment fees shall be as billed as presented to me prior to the start of treatment. However, if additional treatment should become necessary to insure an optimal treatment result, I understand that all related fees will be disclosed to me, prior to the treatment being rendered, and that I will be required to provide written consent to receive such treatment.

I further agree that should I breach any term of this agreement it shall not constitute a breach of any other term under this agreement. I acknowledge that I will be held personally responsible for payment of all collection agency commissions, attorney fees and/or court costs incurred by Susan M, King, D.M.D. and Associates, P.S.C. in the collection of my account should it become delinquent.

I grant permission to you, or your assignees, to telephone me at my home or place of business to discuss matters related to this financial policy or agreement.

I have read the above condition of treatment and payment and agree to their content.

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

_____ _____

Signature of Guarantor of Payment/Responsible Party **Date**

SUSAN M. KING, D.M.D. AND ASSOCIATES, P.S.C.
555 West Lincoln Trail Boulevard, Suite 43
Radcliff, KY 40160
Phone: (270) 351-6201 <> Fax: (270) 351-6276