

# Ryder Waldron DDS / Howard A. Trotter DDS

## 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 costs 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** at the time treatment is 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 our charges will be paid in full by an insurance company.

**A monthly service charge at a fixed rate of 1.5% per month 18% per annum of the unpaid balance as of the last day of each month will be assessed and added to the balance on accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six(6) months from the date of the patient examination.**

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, the fees charged for the dental services provided by the dentist or his employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event that my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentists 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. I also agree to let this office leave messages concerning appointments and/or results on my answering machine, voice mail, or with a family member.

I authorize the dentist or his designees to release financially identifiable information and 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.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

Missed appointments are subject to a fee.

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

\_\_\_\_\_  
Signature of Patient, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient