Ryder Waldron 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. **Insurance Co-payments are required at the time of service.**

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.

Patients agree to pay a finance charge of one and one-half percent (1 ½%) per month on all amounts due and owing to Ryder Waldron DDS/Convenient Dental Care. Financial arrangements must be made at time of treatment.

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 fifteen (15) days of billing if credit shall be extended. 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 billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. A collection fee of 40% will be assessed to my existing balance.

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.

This agreement supersedes all prior agreements 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 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.

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Signature of Patient, parent or guardian	Date	Relationship to Patient