

Cameron M. Workman, DDS, P.C.

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. The 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 services are rendered. 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 service charge of 1.5% 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 financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount listed above, attorney's fees, court costs and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. 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 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 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 qualities 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 in paper form to my insurance carrier or any related entities that require such information to be submitted.

I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian

Date