FINANCIAL POLICY

David W. Mills, D.D.S.
26300 Euclid Avenue
Cleveland, Ohio 44132

216-261-2580 (Phone)
216-732-9176 (Fax)

This is an agreement between David W. Mills, D.D.S. and the Patient/Responsible Party named on this form. By signing this agreement, you are agreeing to pay for all services received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, any payments or credits applied to your account during the month and the finance charge, if any. Statements will close by the 20th of each month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date stated. There is a fee (currently $25) for any checks returned by the bank.

Payment options if you do not have dental insurance: We accept cash, checks, Visa, MasterCard and Discover. Payment is expected on the day treatment is rendered. When treatment involves laboratory fees, 50% of the total fee is due on the preparation date and the balance is due on the placement date, unless other arrangements have been approved.

Payment options if you have dental insurance: Any amount not covered by your insurance is due at the time services are rendered. Insurance is a contract between you and your insurance company. As a courtesy to our patients we will file your insurance claims for you.

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within ninety (90) days of the time the item was added to the account. (This allows adequate time for your insurance to make their payment.) The Finance Charge will be computed at the rate of 1.5% per month or an Annual Percentage Rate of 18% percent. The finance charge on your account is computed by applying the periodic rate 1.5% to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 90 days ago, and then subtracting any payments or credits applied to the account during that time.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect.

PATIENT'S NAME: _____ SIGNATURE:_____

RESPONSIBLE PARTY:_____ SIGNATURE:_____
(If other than patient)

DATE:_____