We believe it is important not only to provide the highest quality dental care, but to make the care affordable to our patients. We have made arrangements for our patients, which allow payment to be convenient and flexible. We are committed to helping you receive the dental care you desire with the most pleasant dental experience possible.

Please initial each paragraph after reading. If you have any questions please ask our Financial Coordinator prior to initialing.

___ Full payment for professional services is due at time of service. As a courtesy to our patients, Aristo Dental will bill your insurance company. Any co-pay and deductible is due prior to treatment.

___ If your insurance company was billed and payment is not received within 45 days, the balance will be transferred to the patient's responsibility. It is the patient's responsibility to obtain payment from the insurance company or negotiate a settlement on any disputed claim. Any portion of the bill not paid, or denied, by the insurance carrier, will be the patients' responsibility.

___ You must inform our office if you have a new insurance carrier or if the insurance carrier has relocated to a new address. Please send us a copy of the front and back of your new insurance card so we can update our records. In the event your insurance coverage or our plan participation changes to a plan where we are not participating providers, you will be responsible for payment of all fees at the time services are rendered.

___ Upon receipt of payment from your insurance company, yo will receive a statement showing your balance due. Payment is expected within fourteen (14) days.

___ I understand that a $35 fee will be applied for ant returned checks.

___ In the event your bill is not paid and is turned over to our professional collection agency, you will be responsible for all collections costs and will be charged an additional 30% of your outstanding balance. Also information will be given to them and may include, but is not limited to, your name, address, phone number, social security number, employer and employer phone number.

___ Full payment for services associated with a motor vehicle accident or Workers Compensation are due at time of service. It is your responsibility to submit claims to the corresponding insurance.

___ Our office does request and appreciate at least 48 business hours notices for any cancellations. Please be sure of the reserved time that you have set with us as we are reserving this time with the Doctor and our team. Failure to notify our office may result in a $75 fee for a reservation with our hygienist and a $100 fee for a reservation with our Doctors.

I authorize the release of any necessary information regarding my dental health to mty dental insurance companies. I hereby authorize payment directly to Aristo Dental of the group insurance benefits otherwise payable to me. I understand that I am fully responsible for any portion of my bill not paid by my dental insurance company within 45 days of a claim being submitted. I understand that payment is due for services rendered at the time of treatment, unless other arrangements are made in advance, and that a late charge of 1.5% per month may be added to any unpaid balance. I also agree to pay for all reasonable attorney's fees and court costs should legal action be necessary to recover this debt.

_____ _____

Patient Signature or Responsible Party Date