FINANCIAL RESPONSIBILITY AGREEMENT

Our offices are committed to meeting or exceeding the standards of infection control mandated by federal and state governments. In order to keep our fees down and provide quality dental care with the latest in sterilization techniques and dental procedures, we have established the following financial policy:

1. **PAYMENT POLICIES:** Payment for professional services is expected at the time of service. Payment may be made by cash, check, credit cards or through other approved lending agencies. Insurance is generally accepted, however any deductible and estimated co-payments (the part of dental fees not covered by your dental policy and deductible) are payable at the time of service.
2. Patients having dental insurance must provide documented evidence of coverage, i.e. insurance card, claim form.
3. Patients who utilize Dental Health Care Insurance should remember that professional services are rendered and charged to the patient not to Insurance Company. Thus the patient is responsible for all charges not paid by their insurance company.
4. Insured patients are expected to take care of their co-payments as services are rendered. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account.
5. We allow a reasonable time for your Insurance Company to pay for treatment.
6. If you have any questions we shall of course, assist you. Your eventual reimbursement will be determined by your insurance carrier.
7. In the event, the charges incurred are not paid in full when due and collection action is instituted, whether by a collection agency or attorney, or both, you agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs associated with such collection activity including, but not limited to, reasonable collection agency fees, attorneys fee, court cost and/or any other expenses incurred in its collection, according to 1989 statues of the State of Tennessee.
8. **INTEREST:** Any account remaining unpaid 30 days from date of service, CDC has the right to charge interest at the rate of 1.5% per month of any unpaid balance (18% per year) unless prior payment arrangements have been approved.
9. **LABORATORY DENTAL PROCEDURES:** Crown, Bridges, Partials, Dentures, etc: A nonrefundable laboratory retainer fee of half of the charged fee is due on the day impressions are taken unless prior payment arrangements have been approved.
10. **PAYMENT PLANS:** On large treatment cases financial arrangements will be discussed and approved prior to the first treatment visit.
11. **CHILDREN:** The parent or guardian who brings the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibility another parent or guardian may have to this child.
12. **TMJ:** Payment in full must be received when treatment begins regardless of insurance coverage. We will be glad to assist you in filing for the insurance company to reimburse you.
13. **CANCELLATION POLICY: Patients are expected to notify the office at least 24 hours prior to their scheduled appointment if they cannot keep this appointment. Failure to notify us may result in a charge of $50 for the first missed appointment, $60 charge for the second missed appointment and $85 for the third missed appointment.**

    If notice is not given we may dismiss you as a patient, unless there is a legimate reason for failure to keep the appointment.
14. It is agreed and understood that under the provision of the Fair Credit Reporting Act, I have been notified that Clarksville Dental Center may perform a credit check to offer different types of financing. I release all persons who furnish such information to Clarksville Dental Center from liability and damages.
15. Customer, Patient, Borrower, Guarantor, etc. agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.
16. I hereby authorize **CLARKSVILLE DENTAL CENTER** to affix my name to any and all claims or documents as related to any and all health benefits due me.

I have reviewed the treatment plans and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

This "Signature of File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

I, the patient or duly authorized representative of the patient, accept full responsibility for all fees regardless of dental insurance coverage.

_____ _____

Patient Name (Please Print) Date

_____ _____ _____

Patient / Parent / Guardian / Authorized Representative Signature Relationship to Patient Date

I have reviewed the above information and conditions with the patient or his/her representative and he/she appears to fully understand these conditions.

_____

Signature of Registering Personnel / Clarksville Dental Center / 1301 Peachers Mill Road / Clarksville, TN 37042