GREENWAY
FAMILY DENTAL

Consent for Services and Financial Policy

I the patient understand that services rendered to me by Greenway Family Dental are my financial responsibility and that the provider will bill my insurance company I have provided them as a courtesy.

I authorize my insurance company to pay my benefits directly to Greenway Family Dental and I understand I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY! This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the opportunity to pay me ESTIMATED deductible and co-insurance at the time of services and have chose to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company. I authorize the provider to release my information necessary to adjudicate the claim and understand there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also understand that should my insurance company send the payment to me, I will forward the payment to Greenway Family Dental within 48 hours. I agree that if I fail to send payment to the provider that they are forced to proceed with the collections process at which time my balance will have an additional 30% fee of whatever the balance is added to my account before sent to collections. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to Greenway Family Dental. Any violations of this agreement will, at provider's election, terminate patient charge privileges with Greenway Family Dental.

- As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
- All emergency dental services, or any dental serviced performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangement are made.
- Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help repair the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 2% per months (24% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- I understand that any fee estimate for this this dental care can only be extended for a period of six months from the date of the patient examination.
- I understand that a minimum $30 charge will be added to my account for non-sufficient funds charges incurred by Greenway Family Dental's bank or of my own personal bank.
- I understand that Greenway Family Dental has a 48 hour cancelation policy. If you are unable to keep your dental appointment call the office (623-546-3511), we do not accept voicemail for cancelations. For missed appointments we charge $25.00 per hour of the appointment you missed.
- In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment or within (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit be instituted hereunder.

Print Name:_____

Sign Name:_____

Date:_____