FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Dr. Jason May as your dental health care provider. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to your dental treatment.

1. **Payment for services is due at the time services are rendered** unless other specific financial arrangements are made. We accept cash, checks, Visa, MasterCard, American Express, and Care Credit.

2. Your dental plan is a contract between you and your plan provider. We are not a party to that contract. As a courtesy, we will submit claims to the dental plan you have listed with us. In order to facilitate claims processing, you must provide all dental plan information and any changes to our office. Your bill is your responsibility whether your dental plan pays or not. At times, you may need to contact your dental plan regarding slow or non-payment of your claim(s). **If your dental plan has not paid us within 30 days, you must pay the outstanding balance.**

3. A $25.00 fee will be charged for all returned checks.

4. Your appointment is reserved specifically for you. **We must be given at least 24 hours notice for an appointment change or cancellation.** If we are not given notice for missing an appointment, **a $45.00 missed appointment fee will be charged to your account.**

5. In the case of minor children the parent or guardian granting permission for treatment is responsible for the account regardless of divorce decree or court order.

6. Interest will be charged at the annual rate of 18% on any unpaid balance exceeding 30 days.

In consideration for the professional services rendered to me by Dr. May or staff (or at my request for my minor child or ward), I agree to pay the reasonable value of said services to said dentist. I authorize Watertree Dental Care to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper to my dental plan carrier or any related entities that require such information to be submitted.

Should my account be turned over for collection, I agree to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collections 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 grant my permission to you or your assignees to telephone me at home or at my workplace to discuss matters relating to this form.

By signing below, I assume responsibility for payment and authorize this office to bill my dental plan. I certify that I have read this form in its entirety, and I hereby agree to abide by the conditions outlined therein.

Patient
Name_____
_

Responsible Party (if other than patient)_____

Signature of Patient or Responsible Party_____Date_____