

## Truth in Lending Statement

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
*(Last, First, Middle)*

As a condition of your 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 and any dental services performed without previous financial arrangements must be paid for at the time the services are rendered.

Patients who carry 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 prepare the patient's insurance forms, assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. The dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month (18 per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

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 five (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 hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_