The Henderson Dentist

Please Initial each and sign below:

FINANCIAL AGREEMENT

By signing below, you acknowledge and understand that payment in full for all services is required at the time of your visit, unless prior arrangements have been made. **Initials_____**

INSURANCE FILING

By signing below, acknowledge and understand that you (the patient) are ultimately responsible for payments in full on your account, not the insurance company. We do file dental insurance claims as a courtesy to our patients. You understand that we can only make ESIMATES regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, you understand that the remaining balance is due and payable immediately by you. **Initials_____**

ASSIGNMENT OF INSURANCE BENEFITS

By signing below, you hereby assign all insurance benefits directly to our office which are otherwise payable to you. You also hereby authorize the release of any information relating to any claims. You understand that you are financially responsible for charges not paid by this assignment.

Initials_____

DELINQUENT ACCOUNTS

By signing below, you acknowledge and understand that all delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates. **Initials_____**

COLLECTION PROCEEDINGS

By signing below, you acknowledge and understand that in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any and all reasonable collection costs and/or attorney fees, in addition to the balance owed. All accounts turned over to a collection agency forfeits any pass special fees and/or discounts. Such special fees and/or discounts will be reversed, and you will be responsible for payment of regular fee for procedures at the time of service. **Initials_____**

USE OF PHOTOGRAPHS, VIDEOS, AND IMAGES

By signing below, you acknowledge and understand that photographs, videos, and other images, such as X-rays, and other records maybe created during your examination, treatment, and follow-up care. I give my permission for such items to be used for purpose of research, education, advertisement, or publication. Identifying information will be omitted. You also understand that you have the right to refuse to sign this acknowledgement. **Initials_____**

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge and understand that you have received and read a copy of the notice of privacy practice. **Initials_____**

Patient Name (Please Print)_____

Patient Signature:_____

Date:_____