Matthews Dental

Jeremy B. Matthews, D.M.D
Austin K. Woodfield, D.M.D

(801) 766-4944
1305 North Commerce Drive Suite 220
Saratoga Springs, UT 84045

Office Financial Policies and Federal Truth-in-Lending Statement

PAYMENT IS DUE AT THE TIME OF SERVICE - As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. Emergency dental services or any dental services performed without previous financial arrangements must be paid in full at the time services are rendered.

COURTESY INSURANCE CLAIM & RELEASE - Patients who oresent dental insurance as a form of payment understand that all dental services provided are charged directly to the patient and that the patient is personally responsible for payment of all dental services. As a courtesy to our patients, this office will help prepare the insurance forms or assist in making collections from insurance companies and will credit any such collection received to the patient account. This dental office cannot render services on the assumption that our charges will be paid in full or in part by an insurance company.

I understand and agree that dental Insurance policies are an arrangement between an insurance carrier and myself and that the office only provides ESTIMATE of insurance co-payment. I understand that my recommended treatment will be evaluated at 6 month intervals and an updated treatment estimate provided to me. Insurance claims remain open until payment. If no payment is received, the claim will be closed after 60 days and I will be invited to contact my insurance company directly for reimbursement.

I also assume responsibility to inform the office of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined.

I authorize release of any information, including diagnosis and records of any treatments or examinations rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or any other agency necessary for the collections of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. This release is solely for the purpose of facilitation billing and reimbursement directly to the doctor of insurance benefits under which I'm entitled. This authorization is considered to be effective for present and all future insurance claims.

COLLECTIONS/CHARGES - A monthly service charge at the fixed rate of 18% per month of the unpaid balance as of the last day of the month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial agreements are made.

In consideration for the professional services to be rendered to me (or with my permission to my minor child of ward) by the dentist, I agree to pay the fees charged for such services provided by the dentist or licensed employee at the time services are rendered, or within (5) days of billing, if credit is extended by the dentist. In the event my

account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to which the account is assigned for collection purposes including a 20% collection fee, and interest at the rate of 18% per month.* In addition, attorney fees and court costs are my responsibility, should such measures be taken.

I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

DISHONORED FEE - Matthews Dental and Orthodontics charges a $25 fee for any check or credit card that is dishonored for any reason.

PERMISSION TO CONTACT - I grant my permission to Matthews Dental or assignee to telephone me at home, at my workplace, or on my cell phone to discuss matters related to this form. I agree to allow text messages with pertinent information to be texted to my personal cell phone number. I also agree to allow the office to leave voice mails concerning appointments and/or results. I also agree that my information may be left with a family member in the event I am not available, and someone else answers the number I have provided for this office to use to contact me.

48 HOUR CANCELLATION POLICY - Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. The office reserves the right to charge $50 per hour scheduled as a fee for any appointment that is missed/cancelled without giving the business 48 hours notice. This decision is at the discretion of the office.

SAFETY - For the safety of yourself and our other patients, no one is allowed in the operatory room throughout the course of your treatment. This includes both children and adults. We have a waiting room available for family members not being treated.

This agreement supersedes all prior signed agreements, including an and all mediation or mediation/arbitration agreements. I acknowledge that any prior agreements related to financial agreements or quality of care are null and void.

I acknowledge that I have received a copy of this office's PRIVACY POLICIES. I agree to disclose to the dentist the names of individuals with whom I GIVE MY PERMISSION TO DISCUSS MY DENTAL CARE.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREIN.

Patient/Guardian Signature:

______________________________ Date: ______________

Printed Patient Name: ______________________________