



PIKE DISTRICT
SMILES

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION AND ASSIGNMENT, AND FINANCIAL AGREEMENT:

I _____ authorize Pike District Smiles to perform dental treatment and to furnish my insurance carriers with any medical information necessary to process this claim. I assign Pike District Smiles all payments for services to me or my dependents.

I understand that I am responsible for payments in full for all treatment, whether or not it is paid by my insurance company.

Any insurance claims pending beyond 60 days are my responsibility and will be promptly paid.

Any payment later paid by my insurance company will be reimbursed. If I have an unpaid balance 90 days after the service is provided my account may be referred to a collection agency unless prior financial arrangements have been made.

- Payments are expected at the time of service.
- Active insurance cards are expected at the time of service.
- If a balance is due at our office Pike District Smiles will send out a bill within 10 days of the received explanation of benefits.
- I agree to pay interest on the total unpaid monthly balance over 60 days at the rate of (18%) APR. I understand that it is my responsibility to follow up with Pike District Smiles to make sure my account is up to date.
- I agree to pay collection costs, attorneys' fees and court costs after 90 days of an outstanding balance. • I authorize my employer to release all information regarding employment and salary information. • I authorize communications via email/telephone.
- We are not a party to divorce decrees. Either parent may be responsible for their children's expenses.

• If patients are disrespectful or behave inappropriately toward our dental staff, we reserve the right to refuse further treatment. Maintaining a safe, respectful, and professional environment is essential for both our team and our patients. Disruptive, abusive, or threatening behavior will not be tolerated, and individuals who engage in such conduct may be formally dismissed from the practice

Missed or cancelled appointments, without 24 hours prior notification, may be charged a missed appointment fee of \$75.00 There is a fee of \$75.00

for all returned checks.

Signature of Responsible Party

Date