

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 24-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least twenty-four (24) hours in advance to avoid a missed appointment fee of up to \$30. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your records or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Olaf Haerens, M.P.H., D.D.S.

Without any reservations, I agree to abide by the policies outlined herein.
Form completed by:

Name _____ Signature _____

Relationship to child _____ Date _____

Are you the person legally responsible for this child? Yes _____ No _____

Reviewed by staff member _____ Date _____