THOMAS CONNER and Associates

Financial Agreement

Patients Without Insurance:

Payment in full is expected at the time of service. In case of extensive treatment, financial arrangements must be made with the front office personnel, prior to the treatment or therapy being given.

Patients With Dental Insurance:

We are happy to file your services with your insurance company as a courtesy for you. We do not accept responsibility for following up on or re-filing insurance claims, which have been denied. You are responsible for any charges that are incurred in this office regardless of coverage or not. Please be prepared to pay your co-pay or percentage at the time of service. You are also responsible for any uncovered service that is rendered and for all differences not paid by your carrier.

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to myself and/or my child's health. It is my responsibility to inform the dental office of any changes in my or my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentists to release any information including diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentists or the dentist group insurance benefits other wise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

In the event that your personal balance is not paid within 30 days of the charge, interest charges/finance charges will be added to the balance owed. The monthly rate is 1 ½%. The annual percentage rate is 18%. This will apply to all accounts regardless of whether you have insurance or not.

*** For all minor children brought into this office for treatment, we consider both parents to be financially responsible for all costs incurred in treating your child regardless of which parent brings the child to this office. We will bill the parent tat brings the child into the office. We will not bill the other parent in cases of divorce.

*** Please be aware that by making an initial or established patient appointment with one of our dentists, hygienists or dental assistants, you are agreeing to abide by the billing policies of our practice. There will be a fee, billed to you personally, not your insurance company, if you do not provide at least 24-hours notice of a cancellation of an existing appointment. This policy will be enforced for both new patients, as well as established patients. In addition, there will be a fee, billed to you personally, not your insurance company, if you do not show for your appointment. There are not dental insurance companies that will pay for a missed appointment or "No Show" appointment. Our staff will be happy to answer any further questions regarding this policy.

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Acknowledgement of receipt of this policy by
Signature of Patient or Responsible Party if minor:

Date

I/We hereby assign Thomas A. Conner, DDS, all rights and benefits pertaining to services rendered under any insurance policies and I/We authorize My/Our Physician to release whatever medical information is necessary to file said insurance claim. I/We jointly and severally promise to pay My/Our account when due and if My/Our account is referred to a collection agency or attorney for collection that I/We agree to pay all costs of collection and expenses including, but not limited to any collection agency and/or attorney fees of not less that Forty Percent (40%) and court costs whichever are applicable. I/We waive the benefit of the Homestead Exemption.

_____ _____

Print your name here
Sign and date here

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