First Smiles Children's Dentistry
1801 Tully Road, Ste B. Modesto, CA 95350

Terms and Agreements

Patient Name: _____

Release of health information:
The provider may disclose all or part of the patient's health record in accordance with the Health Insurance Portability and Accountability Privacy Rule (HIPAA) to facilitate patient treatment, healthcare operations or financial obligations. A copy of this office's HIPPA policy will be provided upon the patient's initial visit to the office.

Financial agreement, Assignment of benefits, Authorization for treatment:
I authorize treatment of the person named above and agree, irrevocably, whether signing as agent or patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to the provider named above, and/or any assisting physicians for services rendered. *(A copy of this assignment is valid as original).*

I understand that my insurance will be billed by this office strictly as a courtesy and all charges are my responsibility to resolve. I agree that my payment will not be delayed or withheld because of any insurance coverage or payment of claim interruption. I understand that this practice is committed to providing the best treatment for its patients regardless of an insurance company's arbitrary determination of usual and customary rates or treatment.

As required by law, I am hereby notified that a negative report may be submitted to a credit reporting agency if I fail to fulfill the financial terms of this agreement. Should my account be referred to an attorney or collection agency for collection proceedings, I, the undersigned agree to pay actual attorney fees and collection expenses in addition to balance owed this practice.

Acceptable methods of payment:
I am aware that payment is due at the time services are rendered unless both parties have agreed upon other arrangements. Acceptable forms of payment are cash, personal check and major credit cards.

Additional fees:
1.) A $25.00 fee in addition to the banking fee may be charged on all returned checks.
2.) 1.5% monthly finance charge will be assessed on all accounts not settled within a 60-day cycle after determination of patient responsibility.
3.) A $40.00, 48 hour late cancellation or failed appointment fee may apply.

I understand and agree to the terms and agreements listed above. I certify to the best of my knowledge that my answers provided on the reverse side of this form are complete and accurate.

Patient or Parent/Guardian Signature Date

Provider Signature Date
Revised Jan 2013