HILLCREST
DENTAL
Ryan Buckwalter, DDS

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

I _____ authorize Hillcrest Dental to perform dental treatment and to furnish my insurance carriers with any medical information necessary to process this claim. I assign Hillcrest Dental 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.
- New patients are expected to pay in full on their first visit, regardless of insurance coverage. The insurance benefit will be refunded or assigned to the patient.
- I agree to pay interest on the total unpaid monthly balance at the rate of (18%) APR, beginning 60 days after treatment.
- I agree to pay collection costs, attorneys' fees and court costs.
- 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.

Missed or cancelled appointments, without 24 hours prior notification, may be charged a missed appointment fee of $30.00

There is a fee of $50.00 for all returned checks.

_____ _____

Signature of Responsible Party Date

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