CHERRY LANE DENTAL

FINANCIAL POLICY

PAYMENT POLICY – All deductibles, co-payments, and patient responsibility payments are due at the time of service. There is a $25.00 service charge on returned checks.

INSURANCE – We are happy to bill your insurance as a courtesy to you IF provided all current insurance information/documents. While we do our best to get a general breakdown of insurance policies, it is still the patient's responsibility to know their policy. Please be aware that some or all of the services provided may not be covered benefits.

*Our fees are based on what is usual and customary for the area. You are ultimately responsible for any charges incurred regardless of what your insurance covers or determines "usual or customary".

MINORS – Treatment may be denied without a parent/guardian present or without prior consent. The responsible adult accompanying the minor will be responsible for payment at the time of service.

*Cherry Lane Dental is NOT responsible for collecting from multiple sources (i.e. divorced parents).

NO SHOW/CANCELLATIONS – 48 hours notice is required to cancel any scheduled appointment. If required notice is NOT given, Cherry Lane Dental reserves the right to charge the patient or responsible party a $25.00 fee per occurrence. Upon third violation of the policy, dismissal from our practice may occur.

INTEREST – We reserve the right to charge interest beginning 90 days from the date of service billing starting at 1% per month.

COLLECTIONS – In the event that **DEBTOR** becomes delinquent and payment is not made on amounts owing under the terms if this agreement, and the balance is place within a licensed collection agency, **DEBTOR** agrees to pay the fees of the collection agency, which amount is theretofore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

I have read and understand this financial policy. I agree to the above terms and conditions.

Responsible party PRINTED

Responsible party SIGNED

Patient name IF DIFFERENT DATE

Cherry Lane Dental
1104 W. Cherry Lane
Meridian, Idaho 83642
208-888-7889

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Cherry Lane Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cherry Lane Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

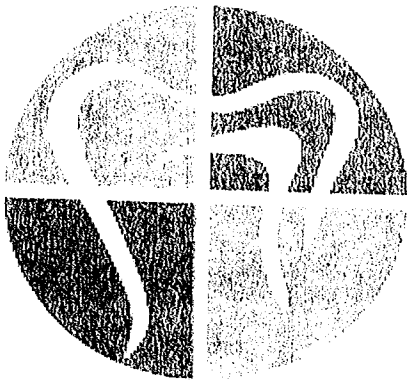
ADDITIONAL DISCLOSURE AUTHORITY				
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY	☐	YES	☐	NO
SPOUSE ONLY	☐	YES	☐	NO
OTHER (*PLEASE SPECIFY*):	☐	YES	☐	NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Cherry Lane Dental

Dr. John Bergloff

I understand that the services being performed today are part of a promotional offer at a discounted price. I am not being charged for X-rays. The X-rays being taken today are for diagnostic purposes only. If at a later date I want copies of these X-rays there will be a charge based on the customary and ordinary fees for those X-rays.

Date: _____

Signature: _____