Dr. Clayton Hansen D.D.S.
Family Dentistry

Office Financial Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patients's account. However, this dental office cannot render services on the assumption that all charges will be paid in full by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or withing thirty (30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected by me in writing, within the time for payment thereof. I further agree that a waver of any breach of any time of condition hereunder shall not constitute a waiver of any further term or condition, **and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter.**

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, To Dr. Clayton M. Hansen.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined heron.

Signature : _____ _____ _____

Patient, Parent or Guardian | Date | Relationship to Patient