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chad c. perry, dds

GENERAL PATIENT AUTHORIZATION

I hereby authorize Chad C Perry, DDS and his staff to render treatment to me during my office visits. In consideration of services rendered or to be rendered, I assign and transfer to Chad C. Perry, DDS any benefits payable to me or on my behalf under any insurance coverage. I agree to fulfill all policy provisions which my insurance companies may require for payment. I hereby understand that I am financially responsible for services provided which are to be paid on the day 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 patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

I understand that a service charge of 1.5% will be assessed each billing month on the unpaid balance on all accounts exceeding 60 days. I realize that failure to keep this account current may result in the practice being unable to provide additional services except where there is prepayment for such services.

I understand that I must give a **48 hour notice** if I need to cancel or reschedule an appointment. Failure to do so will result in a **$75** missed appointment fee.

I authorize Chad C Perry, DDS to release medical information pertaining to my diagnosis and/or treatment, medical history or any other such related information to:

1. My insurance company or its designated representatives
2. Any person(s) or entities financially responsible for my care or treatment
3. Representatives of local, state or federal agencies in accordance with law
4. Employees or representatives of Chad C Perry, DDS for investigation and defense in any claim or cause of action, actual or potential, which is or may be asserted against Chad C Perry, DDS or the employees of Chad C Perry, DDS

I have read the above conditions of treatment of payment and agree to their content.

_____/_____/_____

Signature of Patient or Legal Representative Date Relationship

_____ _____

Printed Name Witness Date