DENTAL PAYMENT AGREEMENT

Payment is required when services are rendered. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore financial responsibility on the part of each patient must be determined before treatment.

Please be aware that insurance is considered a method of reimbursing you for services rendered, and is not a substitute for payment. As a courtesy to you, we will bill your insurance company; however, this is not a guarantee of payment. **You are still obligated for the full amount**.

It is your responsibility to pay any deductible amount, co-pay, or any other balance not paid for by your insurance company. Insurance companies often set fees that are below usual and customary charges. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Please present your insurance card and/or insurance information to our office staff. Feel free to ask any questions about your insurance coverage, we will help you in any way we can. It is your responsibility to know your insurance coverage. Any fees not paid by your insurance company within 30 days will be billed to you.

By signing below, I authorize the release of any dental or other information necessary to process this claim. I request and authorize payment of benefits to Daniel S. Burr DDS, MSD, PC. I grant permission to this office to telephone me at home or at my work place to discuss matters related to this form. I agree to let this office leave messages on my answering machine or with a family member.

A 2% monthly (24% annual) fee will be added to all accounts not current, ie after the first 30 days. There is a $17 statement fee assessed each month that payment is not received. If balance due is not paid in full your account will be turned over to our collection agency.

Please be aware that any appointments not canceled with in 24 hours of the scheduled time will be considered a missed appointment and a fee of $52 per ½ hour will be billed to the account.

I do hereby agree to make the above payments and agree to the terms and conditions thereof. In the event any amount(s) is/are referred to a third party debt collection agency, I agree in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the collection agency or collection attorney should collection procedures become necessary. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

Signature of patient or legal guardian: _____Date: _____

For your convenience we accept the following methods of payment:

-CASH -CHECK *($20 returned check fee)* -VISA -MASTERCARD -AMERICAN EXRESS -DISCOVER