Thomas J. Miller, D.D.S., M.S.
T.J. Miller II, D.D.S., M.S.
Practice Limited to Periodontics and Dental Implants

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Worthington, OH 43085
885-5525

FINANCIAL AGREEMENT

This is an agreement between Drs. Tom and T.J. Miller and the patient named on this form. In signing, you agree to pay for all services provided and give consent to be contacted concerning the following matter.

INSURANCE: Patients who carry dental insurance understand that our office will help prepare insurance forms, assist in making insurance collections and will credit any such collections to the patient's account. If you carry both primary and secondary insurance plans we will file both of them on your behalf; however, your portion due will be based only upon your primary carrier. If an additional payment is received from your secondary carrier, we will issue a credit refund to you. **However, if our office does not receive a response from the insurance company within 90 days you will be responsible for the charges. You will also be responsible for contacting the insurance company to recover payment**.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless we approve other financial arrangements, the balance on your account is due when the statement is issued, and is past due if not paid by the "pay by" date on your statement. Our practice is entitled to take the necessary steps to collect this debt.

CHARGES TO ACCOUNT: We have the right to suspend your privilege to make charges against a patient's account. Any future visits would need to be paid in full at time of service.

REQUIRED PAYMENTS: We do our best to estimate the portion not covered by dental insurance. We require that the remaining estimate be paid for at the time of service**.**

RETURNED CHECKS: Returned checks are subject to a $25.00 fee.

MISSED APPOINTMENT FEE: A fee between $35 and $80 will be assessed to your account after a second failed appointment or cancellation lacking 24-hours notice. This fee must be paid before a new appointment can be scheduled.

DIVORCE: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the person authorizing treatment will be responsible for subsequent charges.

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney or collection agency, the fact that you received treatment in our office may become a matter of public record.

TREATMENT PLAN: I understand that estimated treatment fees for my dental care can only be extended for a period of *six months* from the date of examination.

I have read and agree to the above conditions of treatment and payment. In addition, I give my permission to Drs. Tom and T.J. Miller to render any necessary dental treatment for myself or any dependents.

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Patient Signature (guarantor, if patient is a minor) Date