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

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Worthington, OH 43085
614-885-5525

FINANCIAL AGREEMENT

This is an agreement between Drs. T.J. Miller and Pamela Amundson 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: We must emphasize that as dental care providers, our relationship is with you, as the patient, not with the insurance company. While the filing of insurance claims (assignment of payment is to the insured) is a courtesy we extend to our patients, all charges are the responsibility of the patient. Payment is due at the time services are rendered. For your convenience, we accept American Express, Discover, MasterCard and VISA. We also accept cash, personal checks; however, a $25 service charge is assessed on all returned checks. In addition, financing options are available through CareCredit.

MEDICARE: We are not a Medicare provider as they do not cover any periodontal procedures.

REQUIRED PAYMENTS: We require a $100 deposit to schedule a surgery appointment and $100 for each 2 hour SRP appointment. A **48-hour notice** is required for cancellation or reschedule. If notification is not received within 48 hours, you forfeit your deposit. Full payment is due at the time services are rendered.

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.

MISSED APPOINTMENT FEE: A fee of $50 will be assessed to your account if a 48-hour notice is not given for late cancellation or missed appointment. 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. T.J. Miller and Pamela Amundson to render any necessary dental treatment for myself or any dependents.

_________________________________ ____________________

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