FINANCIAL POLICY

This is an agreement between Rolin S. Henry, DDS, PC as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Rolin S. Henry, DDS, PC.

By executing this agreement, you are agreeing to pay for all services that are received.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:
___ You choose to pay by__cash,__check,__debit, or __credit card on the day treatment is rendered.
___ For treatments over $2000 you are obligated to pay at least 50% on the surgery date and the balance in three months by Automatic Credit Card Payment
___ On extensive treatment, you may prefer to secure a bank, credit union,or other third-party financing for the entire amount and make payments to the lending institution.
PAYMENT OPTIONS IF YOU HAVE INSURANCE:
___You choose to pay your deductible and any out of pocket portions at the time services are rendered by___cash, ___check, or ___credit card.
You choose to pay in full for all of your treatment by___cash,___check, ___debit, or ___credit card. We will request your insurance carrier to send their payments directly to you.
___For treatments over $2000 you are obligated to pay at least 50% on the surgery date and the balance in three months by Automatic Credit Card Payment.
___If we are an out of network provider for your insurance company we will request 50% of the fees at the time of service.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge and any payments or credits applied to your account during the month.
PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due by the end of the month.
CHARGES TO ACCOUNT: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then be paid at the time of service.
REQUIRED PAYMENTS: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these fees.

The Financial Policy continues on the back side of this page.

Patient's name:_____

Responsible party
(if not the patient):_____
Signature:_____ Date:_____