AGREEMENT FOR PAYMENT AND AUTHORIZATIONS

AGREEMENT FOR PAYMENT/ASSIGNMENT OF INSURANCE BENEFITS/COLLECTION FEE/ATTORNEY'S FEE/INTEREST

I, the patient, understand that I am financially responsible to Dr. Josephine Dabhi, D.D.S. for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I hereby authorize and assign payment to be made directly to Dr. Josephine Dabhi D.D.S., for insurance benefits payable to me. This assignment of benefits shall be deemed ongoing until my insurance carrier receives written notice from me that I have revoked this assignment.

I further understand, acknowledge and accept that if I fail to appear at my scheduled appointment without providing an advance 24 hour notice to Dr. Josephine Dabhi D.D.S., or failure to appear at my scheduled appointment is not a result of a health emergency, I agree to pay Fifty Five 00/100 Dollar **per** half hour ($55.00) to Dr. Josephine Dabhi D.D.S., as consideration for reserving a scheduled time with Dr. Josephine Dabhi D.D.S.

I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, of Fifty dollars ($50.00) , may be added to the amount due and that I am financially responsible for the added collection fee. In the event the overdue account is not referred to a collection agency, I understand, accept and agree a, fifty dollar ($50.00) administrative fee to Dr. Josephine Dabhi D.D.S. will be added to the overdue balance, which I am financially responsible to pay.

_____ _____

Initial Date

PAYMENT POLICY

Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment plan, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, MasterCard®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs. For comprehensive treatment plans requiring multiple office visits, a minimum deposit of 60% of the Patient Financial Responsibility amount is required. You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans.

_____ _____

Initial **Date**

It is agreed that Dr. Josephine Dabhi D.D.S. will continue to treat me as long as payment is made pursuant to the agreement. In the event payment is not made when due, or in the event of a discharge in bankruptcy, Dr. Josephine Dabhi D.D.S. has the right to place me in a maintenance status and terminate further treatment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dr. Josephine Dabhi D.D.S. to release any information required in the processing of applications for insurance coverage for services rendered. This authorization provides for the release of objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

A two (2) week notice is required for copies of dental records. A copying fee will be charged, which is allowable under HIPPA and Illinois State Law. Before any records are released all balances must be paid in full, including the copying fee. We also must have a records release form completed and signed.

CONSENT FOR TREATMENT

I hereby consent to treatment provided by Dr. Josephine Dabhi D.D.S. its practitioners, employees or designees and authorize medical and surgical services, diagnostic procedures and medications as deemed necessary if advisable by the practitioners providing treatment.

PATIENT ACKNOWLEDGEMENT

I have read this Agreement and Authorization form and I understand its contents. I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of this form and that any verbal statements may not alter the contents of this form. My signature confirms that I fully accept and acknowledge each section of this form.

Patients Name_____

Responsible Party's Signature _____

Date_____