SHEFFIELD DENTISTRY FINANCIAL POLICY AND AUTHORIZATION FOR TREATMENT

Payment is due at time of service unless a prior financial agreement has been made with the office manager.

Payment for you initial visit is to be paid in full unless you have provided us with accurate dental insurance two days prior to your appointment date. We accept and file dental insurance as a courtesy to our patients. Dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. If we are able to verify your benefits, then you will be responsible for any deductible, copay or percentage at each appointment. Please be aware that most dental insurance companies will not provide us with their fee schedule, therefore all information given to you is an estimate.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. I hereby authorize payment directly to Sheffield Dentistry for insurance benefits otherwise payable to me if applicable. If I terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.

I hereby authorize Sheffield Dentistry to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information I provided on the medical history is accurate to the best of my knowledge. I have been given a Notice of Privacy Practices and hereby grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payors and/or health professionals by any method, including electronic transfer.

PATIENT OR RESPONSIBLE PARTY

PRINTED NAME: ____

SIGNATURE: ____ DATE: ____________________