Southeastern Dental Associates of Soddy Daisy, PC
Financial Policy

Please read the following information carefully before signing in the designated area. The guidelines that follow explain the financial policy for this dental practice.

1. If you have insurance coverage, please understand that this is an agreement between you and your insurance company. You are responsible for your bill regardless of the status of your insurance claim.
2. Initial examination charges are expected to be paid in full when services are rendered.
3. Emergency examination, Radiographs (x-rays), and other treatment charges are to be paid in full when services are rendered.
4. I hereby authorize Southeastern Dental Associates of Soddy Daisy to release to my insurance company or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me.
5. If your treatment requires lab service, you will be required to pay 50% of the charges on the day that impressions are taken and the remaining 50% on the day the prosthesis is delivered.
6. In the event your account is referred to a collection agency or attorney for collection, you will be responsible for all collection fees including court costs and reasonable attorney fees.
7. I hereby consent and agree that any action to enforce this account shall be brought in a court of competent jurisdiction in Hamilton County, TN and the understood hereby waives any defense of forum non conveniens.
8. There may be a fee charges for appointments cancelled without a 24 hour notice.
9. If a credit or overpayment is received then that amount will go towards future work if indicated in patient's chart. If no other work is needed or a request from patient then credit or overpayment will be refunded.
10. By signing this financial agreement, you authorize payment of the dental benefit directly to Southeastern Dental Associates of Soddy Daisy.

I, the undersigned, hereby agree that I will guarantee the payment of the bills for the services rendered by Southeastern Dental Associates of Soddy Daisy for the patient noted below. If I am married, this guarantee extends to my spouse. I further agree that if an insurance company requests that any money received as payment on this account be returned, then I am responsible to pay that money to Southeastern Dental Associates of Soddy Daisy. I further agree that said bill will be paid upon receipt. If not then a balance over 30 days will be charged a late fee. The undersigned further authorizes the transfer of overpayment to be applied to any account on which undersigned is a patient, guarantor, or otherwise legally responsible.

I have read and understood the above agreement and accept all terms listed.

Guarantor Signature/Patient Name **Date**