John White, DDS, MAGD, FADI • 7 Walden Ridge Drive, Suite 100 • Asheville, NC 28803
tel: 828.684.3020 • fax: 828.684.5544 • email: office@johnwhitedds.com • web: www.johnwhitedds.com

MASTER ACADEMY OF GENERAL DENTISTRY FELLOW ACADEMY OF DENTISTRY INTERNATIONAL

Conditions of Treatment

INSTRUCTIONS: If hand writing, please fill out in black pen ink only.

Payment for Services

Payment for services rendered is expected at the time treatment is rendered. As a condition of treatment by this office, financial arrangements must be made in advance.

In consideration for the professional services rendered to me, the patient, by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fee necessary to collect funds.

A fee of $35 will be charged for all returned checks.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Sedation

For patients requiring sedation, we pre-order your medications prior to your appointment. We request payment of the sedation fee to reserve the necessary time and medications for you. Please note that if you are unable to keep your sedation appointment, all sedation fees charged are non-refundable.

For Patients with a Dental Insurance Plan

Patients with dental insurance plans must understand that all dental services are charged directly to your account and that you are personally responsible for payment of all dental services rendered. At the time of service, our office will estimate the amount that we expect to receive from your dental plan provider. Any remainder is due at the time of service. As a courtesy to you, our office will help prepare your plan's forms and assist in making collections from insurance companies and will credit any collections to your account. All claims not paid to us by your dental plan provider within 45 days of treatment will be due immediately, and billed to you. Any insurance amounts collected after this period will be returned to you as reimbursement.

Fee Estimates

As a patient, I understand that any fee estimates for dental care can only be extended for a period of three months from the date of examination.

Appointment Scheduling

We respect your time and your busy schedule. That's why we strive to stay on-time in our schedule throughout our day. We ask that you please arrive on-time so that we may complete your scheduled treatment. This will allow our office to stay on-schedule for our other patients.

Appointment Cancellation

We understand when emergencies arise that you may need to reschedule an appointment. If possible, we appreciate 2 business days' notice for rescheduling your appointment for convenience. For appointments cancelled with less than 1 business day notice, your account will be charged a $65 fee.

❑ I acknowledge that I have read the above section title "Conditions of Treatment".

❑ I authorize the office of Dr. John White to take x-rays, study models, photographs or other diagnostic aids as deemed appropriate to make a thorough diagnosis of my dental needs.

❑ I understand that x-rays, study models, and photographs may be used by this practice, without use of my name, for the purposes of patient education, advertising or any other lawful purpose and I release and forever discharge Dr. John White from any claim, demands, or liability on account of such use or the quality of the reproduction of the materials provided.

❑ I acknowledge that I have received and reviewed a written copy of this practice's "Notice of Privacy Practices", that explains how health information may be used and disclosed and how I can get access to this information. I authorize the release of information under the "Notice of Privacy Practices".

Signature of patient, or parent, or guardian (responsible party): ____

Print Name: ____________________________ Relationship to the patient: ________________ Date: _____/_____/_____