Financial Policies and Agreement
For the Dental Office of
Dr. Gary B. Southerland

Patients Name: _____

Payment is due at the time of service except in the case where more than one appointment is required (crowns, bridges, dentures, root canal treatments). We accept cash, local personal checks, Visa, MasterCard, American Express and Discover. If this office is able to accept an insurance company's assignment, the estimate provided by this office is considered as a guideline until final insurance payment is received and the patient's account has been reconciled. Any expected payment from an insurance company is an **estimate** and the patient is responsible for any portion not covered by insurance. **If the patient's insurance company does not pay the claim by the 61st day after treatment, the claim will be billed in full to the patient.**

No balance shall be carried by Dr. Southerland's office for more than 90 days. The policy of this office is that interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to all accounts over 60 days, regardless of insurance involvement. Balances still owing after 90 days can be put on Visa, Mastercard, or Discover. If payment is not completed as agreed and communication has not been made with this office, the office reserves the right to turn the account over to a Collection Agency. All collections charges shall be paid by the patient and Dr. Southerland's office will not be held liable for and damage to the patients credit rating.

The investment needed to complete your necessary dental treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as your treatment progresses, this estimate may have to be revised. You will be consulted before any additional treatment is undertaken. This estimate will be honored provided treatment is completed within 3 months of the exam date.

There will be a $25.00 handling fee for any RETURNED CHECKS.

We DO NOT confirm appointments; our patients are responsible enough to keep their appointments however, if you would like us to call to remind you please let us know.

No charge will be made for changing any appointment provided that 24 hours notice during business hours is given. Otherwise, there is a minimum charge of $60.00 (Hygiene) and $90.00 (Doctor) PER HALF HOUR of failed appointment time. This time has been reserved specifically for you.

The patient (or guardian) agrees to be fully responsible for total payment of procedures performed in this office, including any treatment not a benefit of any dental insurance the patient may have.

I certify that I have read, understood and agree to this. If requested, I may receive a copy of this Financial Policy and Agreement.

Patient's Signature: _____ Date_____
Or Parent/Guardian

Parent/Guardian information: Needed if the patient is under the age of 18 years old,

Name:_____ Date of Birth:_____

SS# :_____Driver's License #:_____

Address:_____ Zip:_____

Employer (name & address):_____

Home phone:_____ Work phone:_____