OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

THORNLEY DENTAL
Mark J. Thornley
104 E. 200 N.
Logan, UT 84321

Financial arrangements must be made and financial responsibility must be determined for each patient beginning dental treatment or services.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental service. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

You will receive a monthly statement on any unpaid balance. A service charge of 1.5% per month (18% per annum) with a minimum charge of $.50 per month, on the unpaid balance will be charged on all accounts exceeding 60 days from the date of service, unless previously written financial arrangements are satisfied.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

In consideration for the professional services rendered by this dental office to me, or at my request to my minor child or ward, I agree to pay the fees charged at the time the services are rendered, or within five (5) days of billing if credit shall be extended. Payment can be made with cash, personal check, Mastercard, Visa, American Express or Discover Card. In the case of default of payment of the fees charged I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should procedures as described become necessary.

I grant permission to this dental office to telephone me at home or at my workplace to discuss matters related to dental services provided or fees charged and/or payments made for such services. I also agree to allow this office to leave messages concerning appointments or other information on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation, mediation/ arbitration or financial agreements. Any such agreements previously signed are null and void.

I authorize this dental office to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have been offered a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have read this form and I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent or Gaurdian	Date	Relationship to Patient