Perry B. Young, D.D.S., Ltd. Diplomate American Board of Oral & Maxillofacial Surgery

FINANCIAL CONTRACT

Patient Name: _____

Person Financially Responsible: _____

Welcome to our office. This form is intended to clarify your financial responsibilities.

PATIENT'S WITH INSURANCE: Please initial each statement below acknowledging that you understand your responsibilities.

_____ We will bill your insurance company for your visits as a courtesy to you. Due to difficulty of obtaining payment from your insurance plan, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify their benefits and/or limitations prior to their visit(s). If we are not providers, are out of network, or a benefit is not covered, you will be responsible for any and/or all of the balance for the services rendered.

_____ I understand that payment for services is due the day the services are rendered. When scheduling surgeries we do require a 10% deposit. Please note that with some insurance carriers, mainly HMO policies, surgeries need to be pre-authorized whereas with PPO and Indemnity policies, pre-authorization is recommended. As a courtesy to our patients we will submit all necessary paperwork and X-rays to your carrier for this process to be accomplished. Dental pre-authorizations usually require 6-8 weeks. If for some reason you do not wish to pre-authorize, you will be responsible for paying the surgery in full if insurance does not pay.

_____ I understand and agree that I am responsible for payment of all charges on my account. If my insurance company fails to pay within 60 days, or denies the claim for any reason, I will be responsible for the full amount due. After the 60 day period the full amount due will begin to accrue interest at the highest rate permitted by the Nevada Law.

_____ I understand and agree that after my insurance carrier processes my claim there could be a balance still remaining to be paid by me and I will pay this balance immediately upon receipt of my patient statement or interest will start accruing immediately.

PATIENT'S WITH and WITHOUT INSURANCE: Please initial each statement below acknowledging that you understand your responsibilities.

_____ If payment arrangements are made, I understand that it is my responsibility to remit payment to the office each month. In the event that a monthly payment is missed the remaining balance will be forwarded to a collection agency.

_____ I understand that outstanding balances must be paid prior to being seen by Dr. Perry B. Young.

_____ If any professional adjustments/discounts were provided during your Financial Consultation and your account is being sent to collections, these courtesies will be waived and will no longer apply.

_____ I understand and agree that if my account is placed into collections, I will be responsible for all the costs of such action. Including but not limited to a collection agency and/or attorney's fees.

By signing below, I have read, fully understand and accept the financial agreement. I hereby agree to render payment in accordance with the terms and conditions set forth. Perry B. Young, D.D.S., Ltd., has the right to refuse providing services if the terms of this contract are not accepted.

Patient Signature: _____ Date: _____

Person Financially Responsible: _____ Date: _____