Financial Agreement

Thank you for choosing ***Dr. Jared M. Theurer & Dr. Chase M. Larsen*** as your dental care providers. The following is a statement of our financial agreement. As a condition of your treatment by this office, financial arrangements must be made in advance.

- ***Payment is due in full at time of service.***
- Insurance holders: Patient portion is due at time of service. Any estimate given is only an estimate.
- We accept Cash, Check, Debit & Credit Cards, and Care Credit
- We provide interest free payment plans through ***Care Credit*** that provides interest free payments on approved credit for up to twelve months.
- A finance charge of 1 ½% per month will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.
- Should collection become necessary, the responsible party agrees to pay the additional collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes. Thank you for your understanding in this matter.

The Facts About Insurance

Please understand we want to extend care to you and to work with you and the insurance coverage you may have.

- Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid by an insurance company.
- Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.
- For your convenience we will ***ESTIMATE*** the portion of your total fee that your insurance company will cover. This is ***JUST AN ESTIMATE***. After insurance benefits, ***you are responsible for ANY UNPAID BALANCE.***

Missed Appointments

We recognize that your time is valuable and that is why we strive to see you at the time of your scheduled appointment. To prevent delays and waiting for others, a patient who is 15 minutes late or more will be asked to reschedule. Please plan to arrive on time for your appointment. If you call after hours, regarding your appointment, please do not leave a message, call the after hour number. If you need to change an appointment, as a courtesy please provide at least ***24*** hours notice so that we may fill your time. ***I understand that I will be assessed a minimum $30.00 fee per half hour for failure to keep an appointment or notify the dental office of a cancellation 24 hours in advance. Our intent is not to add financial burden but to improve accessibility to patients desiring dental care.*** ____________ *(Patients Initials)*

Federal Truth & Lending Statement

I grant my permission to your office that you may telephone me at home or at my workplace to discuss matters related to this form. I have read the entire ***Financial Agreement*** and have had sufficient time to study and understand it, or obtain legal counsel, if so desired. I hereby agree to be bound by all of the foregoing terms and conditions outlined hereon. In the event that the terms of this agreement are not met, I agree to pay the principal amount, plus all attorney fees, court costs, all costs of collection, including 33% of the principal amount turned over to collection law firm in accordance with Utah Code Annotated, sec. 12-1-11. The terms of the paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amount are incurred today or after today.

I acknowledge that I have received a copy of this office's Privacy Policies. I authorize Dr. Jared M. Theurer to perform any procedures as may be deemed necessary to maintain my dental health.

Signature of Patient or Responsible Party _______________________________________ Date _______________

Witness ____ Date ______________