FINANCIAL AUTHORIZATIONS & AGREEMENTS

I understand that all payments are due on the day the service is rendered

FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

In consideration of services and care rendered for today's visit and all future visits, I agree that I am responsible for any and all charges billed by Lakeside Endodontics and I understand that all payments are due on the day the service is rendered. I understand that Lakeside Endodontics will bill my insurance carrier directly and will accept assignment on covered services but I agree to pay deductibles, coinsurance and non-covered services, as determined by my insurance carrier. Upon receipt of a statement from Lakeside Endodontics, I agree to pay all amounts not covered by insurance immediately. To avoid increased fees to all patients, *ANY ACCOUNT BALANCES OVER 30 DAYS WILL BE ASSESSED A FEE OF 1.25% OF THE BALANCE DUE PER MONTH. ALL ACCOUNTS OVER 90 DAYS WILL BE NOTIFIED IN WRITING OF THEIR ACCOUNT BEING TRANSFERRED TO A COLLECTION AGENCY*. There will be a fee of $25.00 assessed to all accounts for returned checks.

If I make a change to my insurance coverage, I understand that it is my responsibility to notify Lakeside Endodontics of this change.

RELEASE OF INFORMATION FOR PAYMENT OF CLAIMS

I Authorize Lakeside Endodontics to release any and all information needed exclusively for the payment of professional charges and to permit representatives of those responsible for such payment the examination and copy of all records relating to the care and treatment received, if requested.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICY OF LAKESIDE ENDODONTICS.

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Printed Name of Patient or Authorized Representative

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Signature of Patient or Authorized Representative **Date**