FINANCIAL POLICY

1580 E. DESERT INN ROAD, LAS VEGAS, NV 89169
TEL: (702) 655-6777 FAX: (702 547-3522

This is an agreement between Smiles Today Dental Group, as a Creditor, and the Patient/Debtor named on this form. In this agreement the words "you", "your" and "yours" mean the Insured/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "ours" refer to Smiles Today Dental Group. By executing this agreement, you are agreeing to pay for all services that are received.

- **MONTHLY STATEMENT:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance and new charges to the account, the finance charge, and any payments or credits applied to your account during the month.

- **PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:**
  - **A:** You choose to pay by cash, check or credit card on the day of which treatment is rendered.
  - **B:** On treatment involving surgery, the payment is due during the week and no later than two days before the scheduled surgery.
  - **C:** We offer special financing through Care Credit.

- **PAYMENT OPTIONS IF YOU HAVE INSURANCE:**
  - **A:** You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check or credit card. (NO POSTDATED CHECKS)
  - **B:** If cannot verify your insurance for reason that we did not have control over, payment is expected for the entire treatment at the time of service.

- **PAYMENTS:** Unless other arrangements are approved by us in writing, the balance on your statement due and payable when statement issued, and is past due if not paid by the end of the month.

- **INSURANCE:** Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance.

- **FINANCE CHARGE:** A finance charge will be imposed on each item of your account which has not been paid within thirty days of the time payment is received from the insurance. In the case in which the insured needs to provide more information to the insurance company, a finance charge will be imposed 10 days after our letter of request or statement. The finance charge will be computed by applying the periodic rate of 1% to the overdue balance of your account.

- **RETURNED CHECKS:** There will be a fee of $35.00 for any checks returned by the bank. If a balance is not paid in 10 days, the account will be forwarded to the District Attorney for more action.

- **PAST DUE ACCOUNTS:** If your account become past due, we will take necessary steps to collect this debt. If we have to refer your account to the collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collections of the balance to a lawyer, you agree to pay all lawyer's fees which incur plus all court costs.

- **WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, the fact that you received treatment at our office may become a matter of public record.

- **DIVORCE:** In case of divorce, the party responsible for the account prior to the divorce or separation remains responsible for those subsequent charges. If divorce decree requires the other parent to pay all or part of the treatment cost, it is authorizing parent's responsibility to collect from the other parent.

- **TRANSFERRING OF RECORDS:** You will need to request in writing and pay the copying fee of $25.00 if you want copies of your records and x-rays sent to another doctor.

- **CO-SIGNATURE:** If this or another Financial Policy is signed by another person, that co-signature

- **EFFECTIVE DATE:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Print Patient's Name	Signature of Patient, Parent, or Legal Guardian
Print Name of Responsible Party	Signature of Responsible Party Date