



Assignment and Release

I hereby authorize payment directly to Willis Family Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid or not paid by insurance. I authorize the above doctor(s) and/or provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and health care operations. I authorize the use of this signature on all insurance submissions.

Financial Policy

Your account will be considered past due if not paid within 90 days of our initial bill. In addition to the principle amount owed, should your account become past due, you agree to pay us liquidated damages calculated as twenty-five percent (25%) of the current principle balance on your account in addition to attorney's fees, court cost, and interest at 1.5% from the date of service. I also understand that I am billed a \$35.00 return check fee for any checks returned for insufficient funds.

Office Policy

A minimum charge may be billed for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment may result in a missed appointment fee of \$50.00 and, should this happen 3 times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. Please remember that once an appointment is made, this time is reserved especially for you.

Consent for Use/Disclosure of Health Information

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this consent.

I, the undersigned, understand and agree to the policies stated above. I certify that the information on this form is accurate, to the best of my knowledge.

Patient Name (Printed)

Date

Signature (Guardian if under 18 years old)