FINANCIAL POLICIES

Thank you for choosing Ronald C. Mamrick, DDS, PC. We are committed to your health and to offering exemplary service. The following is a statement of our Financial Policies. We require all patients to read and sign this document prior to treatment being rendered.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, CREDIT/DEBIT AND VISA, MASTERCARD AND DISCOVER.

INSURANCE

We require co-payments be made at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit. I hereby authorize my insurance benefits to be paid directly to Ronald C. Mamrick, DDS, PC and acknowledge that I am financially responsible for any unpaid portion of my bill.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge a fee at the rate of $25 per half hour of appointment time that was reserved for you.

FEES FOR LETTERS AND FORMS

We are available to fill out forms that you may need (e.g., workers compensation forms, legal forms, etc.) Please be advised that due to the time required to dictate letters/complete forms, there will be a fee for this service. Those costs are not routinely covered by the insurance companies.

RETURNED CHECKS

In the event that a check is returned for insufficient funds, a $35 returned check fee will be added to your account.

COLLECTION FEES

In the event that my account becomes delinquent, I will be responsible for all cost of collection including administrative charges and attorney's fees of 33.3% plus court costs and interest at the rate of 18% annually.

I have read the above Financial Policies and I understand and agree to them.

_____ _____

Signature of Patient or Responsible Party Date

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notices, you may obtain a revised copy.

I have received a copy (copy available upon request) of Ronald C. Mamrick, DDS, PC Notice of Privacy Practices. I understand that I may ask questions if I do not understand information contained in the Notice.

_____ _____

Signature of Patient or Responsible Party Date

I agree that Ronald C. Mamrick, DDS, PC may disclose my health care information to the names I have listed below:

Name: Relationship: Phone number: