RONALD L. RODDY, D.D.S., INC.

FINANCIAL POLICY

Payment Responsibilities: In the interest of maintaining a strong patient relationship we hope to help you find ways to comfortably handle the cost of your dental care and to have them arranged prior to treatment. We do require payment (less estimated insurance portions) at the time of service. We offer financing options through outside healthcare financing companies. We also accept checks and major credit cards. Discounts are offered for payments remitted on the date treatment is scheduled as well. We will assist you in matching your budget with a means of achieving the smile you desire.

Insurance Information: We accept assignment of your insurance benefits from most traditional dental insurance companies. It is important to us that you understand our insurance policies. We must emphasize that our relationship is with you, not your insurance company.

- It is your responsibility to provide us with correct insurance information, as well as changes in coverage or carrier.
- Insurance policies are contracts between you, your employer and your insurance company.
- We will extend the courtesy of submitting your insurance claims once per appointment.
- We require that you render payment for your estimated portion at the time of service.
- It is your responsibility to make sure insurance payments are made in a timely manner.
- In the case of unpaid insurance claims, whether due to denial or unresponsiveness, we require that you remit unpaid insurance balances within 45 days of treatment. You may then seek reimbursement from your insurance company. We may assist you in any claims negotiations, settlements or disputes, but cannot be directly responsible for the collection of such.

Authorization to Accept Financial Responsibility for Posterior Composites: I, the undersigned, understand that most insurance companies reimburse posterior composite (white/tooth colored) fillings at the same amount that amalgam (silver) fillings are benefited for the same teeth. Insurance companies understand, however, that often times it is the preference of the patient and/or treating dentist to utilize composite materials. Under these circumstances I, the undersigned, accept the additional financial responsibility for placement of posterior composites. My actual cost will be determined by deducting the insurance payment amounts from the total charge.

Financial Agreement: For and in consideration of services by Ronald L. Roddy, D.D.S., Inc., I hereby agree to promptly pay Ronald L. Roddy, D.D.S., Inc., at the time services are rendered. I hereby assign and authorize payment directly Ronald L.Roddy, D.D.S., Inc. all insurance benefits and guarantee to pay any balance. I understand these claims are not settled/closed until after all related insurance payments are received, and if there is a remaining balance, I agree to promptly pay the same and forward all insurance benefits received by me for said claims. "No action by Ronald L. Roddy, D.D.S., Inc. shall relieve me of my sole responsibility to fulfill all obligations under any applicable insurance I may have, including my obligation to verify insurance coverage." Should the account become delinquent, I agree to pay interest at the legal rate, from the date of service.

RELEASE OF INFORMATION

I authorize Ronald L. Roddy, D.D.S., Inc., by this written release, to furnish information from the patient's medical record to its agents, attorneys, or any insurer, compensation carrier, healthcare facility or any healthcare provider for reasons of financial assistance for patient care, or to any healthcare provider which his/her physician deems necessary to provide continuity of medical care.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that on I received the Notice of Privacy Practices of Ronald L. Roddy, D.D.S., Inc. which sets forth the ways in which my personal health information may be used or disclosed by Ronald L. Roddy, D.D.S., Inc. and outlines my rights with respect to such information.

MEDICAL HISTORY CERTIFICATION

I agree that the medical information provided is correct and complete. To the best of my knowledge no other treatment has been performed and no other medical conditions exist. I understand that failure to provide thorough and accurate information may be detrimental to my health.

CONSENT TO TREATMENT

I understand that I am authorizing consent to Ronald L. Roddy, D.D.S., Inc. for examination and treatment as necessary.

_____ _____ _____

(Signature of Patient or Authorized Representative) (Print Patient Name) (Date)

This release of information shall be effective until revoked in writing.