

**BOWMAN R. BROWNE, D.D.S.**  
**Authorization and Financial Information**

Patients who are not covered by insurance are expected to pay by cash, check or credit card the day services are rendered.

For those patients who are covered by insurance we will accept assignment of benefits. This means you must agree to:

- I. Authorize this office to release any information necessary to expedite claims.
- II. Authorize this office to bill your insurance company for services rendered.
- III. Authorize payment directly to this office of any insurance benefits otherwise payable to you.
- IV. Endorse any payments you receive from your insurance carrier over to this office for services rendered by our staff.

Most dental insurance plans do not cover 100% of the cost of treatment. Because of this and the extreme delay on receiving payment from the insurance company, you will be asked to pay your deductible and your portion of the charges the day the services are rendered. We will estimate as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After sixty days the balance will be due in full from you. Account balances which are over 120 days past due will receive a 1.5% a month service charge which will be calculated on the 27th of each month based on the present balance.

If patient/guarantor defaults as to any terms of this agreement and this account is referred to an attorney for collection then the patient and/or guarantor/guarantors promises and agrees to pay all collection costs including attorney's fees of 33 1/3% of the principal amount due and owed when turned over for collection and does further agree to pay interest on the unpaid balance from the date that said monies became due and payable.

If requested by you, this office has authorization to forward your radiographs and records to another dentist.

There will be a \$20.00 charge on all returned checks.

This office requires a **24-hour notice** for cancelled appointments. Patients who fail to show for or cancel their appointments without proper notice will be charged for an office visit.

A photocopy of this authorization shall be considered as effective and valid as the original. Your signature below indicates you understand and agree to the above policies.

NAME OF PATIENT \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_

Print Name \_\_\_\_\_

Signature \_\_\_\_\_