



TOWER DENTAL

Protecting Your Smile

Authorization and Acknowledgement

Please read the following conditions for treatment:

- As a condition of your treatment by this office, payment must be made when services are rendered. For your convenience, we offer the following methods of payment: Cash, Visa, MasterCard, Discover and Care Credit. Financial responsibility on the part of each patient must be determined before treatment. A valid Oklahoma driver's license must be surrendered at the time of writing the check to obtain verification. In the event the check is returned unpaid by your bank, you will have five (5) business days to pay your check plus a \$30.00 return check fee. The insufficient check will not be processed a second time. If you fail to pay your insufficient check before five (5) days, it will be turned over to the Bogus Check Division of the District Attorney's office. This office is not allowed to accept payment for any insufficient checks once accepted by the District Attorney.
- If you have insurance, this office will prepare insurance forms, assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by the insurance company. All prices quoted are only estimates and final determination will be made by your insurance company when the actual claim is received.
- This office's *Notice of Privacy Practices* is available upon request. In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). This restriction must be in writing and this office is not required to agree to the request. However, if this office agrees to the request, then they must follow it. I authorize this office to release any information including diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payers and/or health practitioners.
- A service charge of 1 ½ % per month (18% annum) or a minimum of 50 cents on any unpaid balance will be charged on all accounts exceeding 60 days.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay reasonable value of said service to Caltre LLC, dba Tower Dental or its assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition. I further agree to pay all costs, reasonable attorney fees and collection fees if suit be instated hereunder.
- A \$25.00 charge per hour scheduled will be assessed for any broken/missed appointment not cancelled with a minimum of 24 hours notice. If you are late for your appointment, it may be rescheduled.

Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the use of my signature on all insurance submissions. I have the above conditions of treatment and payment and agree to their content. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to notify the dentist at my next dental appointment of any changes to my medical or dental history, employment information, contact information and insurance information.

Signature of Patient/Parent or Guardian _____ Date: _____

Patient's Name (print): _____ D.O.B: _____