Brown Family Dentistry

7126 N Shadeland Ave

Suite B

Indianapolis, IN 46250

317 842 6402 Office / 317 842 6403 Fax

PATIENT NAME (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

We are happy to provide written estimates for treatment. It is your responsibility to understand and make all financial arrangements before treatment.

**INSURANCE:**

Your insurance is a contract between you and your insurance carrier. This office can not alter your contract or guarantee payment from the insurance company. As a convenience to our patient, we will be happy to complete and file your insurance for you whenever possible. It is your responsibility to provide us with all of the correct information to file your insurance.

This office will normally only file the insurance once, after that time it becomes your responsibility. If the insurance does not pay within thirty days, the entire bill becomes your responsibility. This office reserves the right to refuse any forms or types of insurance.

By signing this form you are assigning the insurance benefits to be paid to this office.

**RELEASE OF INFORMATION:**

The undersigned patient authorizes release of all information to, including x-rays, relating to the examination or treatment to health service plans and insurance companies.

The undersigned patient authorizes release of all information to peer review committees or state and local dental associations as requested or any other party the patient requests in writing.

**PAYMENTS:**

All bills are due in 30 days unless payment arrangements are made in advance of treatment. After 30 days this office reserves the right to charge interest. This office also reserves the right to charge for billing after the first bill. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys’ fees, we incur in such collections efforts.

PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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