

Southpark Dentistry

Payment Policy Contract

Patients are responsible for payment, co-payments and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees (\$20) are the responsibility of the adults person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

In addition, I assign directly to **Southpark Dentistry** all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize **Southpark Dentistry** to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care and treatment.

Signature of Patient or Guardian: _____ Date: _____

Witness Signature: _____ Date: _____