GILLETTE
DENTAL PC

Gillette Dental Patient Financial Agreement

By signing below, I agree to pay in full for services rendered to me, my immediate family, and my specified ward (named below) within 45 days from when the services were rendered or goods made available regardless of whether I receive a bill from Gillette Dental, and regardless of my insurance coverage. If I fail to pay exactly as stated herein, and on time, I will pay interest on the amount owed at a rate of twenty-one percent (21%) per year (1.75% per month), starting from the date services were rendered.

I understand that I must sign a separate payment plan agreement for approved in-office financing.

I also understand and agree that Gillette Dental utilizes a collection agency to recover past-due balances, and the collection agency charges Gillette Dental thirty-five percent (35%) to fifty percent (50%) of what they recover. I understand this expense is caused by my failure to pay, and so, in consideration of this loss, if my account is assigned to a collection agency, I agree to pay an additional 35% of the total balance due.

If Gillette Dental or their collection agent utilize the services of an attorney to collect the unpaid balance, I agree to pay for the attorney's fees, including paralegal fees, and costs of collection regardless of whether suit is filed or not. If suit is filed against me, I agree to pay the court costs.

I agree that the principal balance, interest, costs of the collection agency, attorney fees, and court costs are all owed cumulatively.

I agree that if Gillette Dental submits claims to my indicated benefit carriers, it is a professional courtesy, and not a legal obligation. So-called provider billing errors, or other insurance conundrums resulting in non-payment or partial payment from my benefit carrier, shall not be considered a breach of this agreement, and have no effect on my duty to pay the entire balance for the professional services that were rendered in good faith. I agree that I am ultimately responsible for billing my insurance company.

I also agree to pay a $100 Late Cancellation-Missed Appointment fee if I fail to provide notice of cancellation a full twenty-four hours prior to the appointment date and time.

_____ _____

Signature of Patient or Guarantor Date

_____ _____

Print Name of Minor Patient