**Valued Patient Agreement**

Welcome to our office and thank you for selecting us for your dental care. Your needs are our highest priority. Our exceptional and highly trained team is committed to the highest standards of quality to provide you with very best dental treatment. In our office we have created a comforting and relaxing environment where you will feel cared for with personal attention and genuine compassion. This agreement outlines some of our office procedures and provides you with an understanding of what we can expect from each other as we move forward with our relationship.

**Appointments**

Our patients come first. Each appointment is reserved especially for you. We will see you on time and we ask that you be on time for your visit. Failure to make a reserved appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make a reserved appointment (except in cases of emergency) you are expected to call 48 hours prior to that appointment to notify us. There is a $100 fee for all "failure to show" appointments which is donated to the Ronald McDonald House foundation.

**Payments**

You or your guarantor is responsible for payment in full prior to or at the time treatment is provided. Our purpose is to care for your dental health and we provide several options to help you pay for your treatment. Any one of our administrative team members will be happy to discuss our available financial options with you.

**Collections and Credit**

You agree that if a lawsuit or action is brought to collect this account or any portion of it, that you agree to pay a onetime finance charge of $50.00 plus the costs of collection, including but not limited to, taxable and nontaxable costs and disbursements provided by statute as well as attorneys' fees amounting to one-third of the total outstanding balance. You also agree to pay interest at the rate of 1.5% per month (18% per year) on the total balance owed after 30 days from the date that you are first billed until the outstanding balance is paid in full.

You also agree that if The Art of Dentistry, L.L.C. extends credit to you or if your treatment balance is substantial, that The Art of Dentistry, L.L.C. may, at its discretion, request a credit report on you. If The Art of Dentistry, L.L.C. does not grant credit to you based on a credit report, you will be told why credit has been denied and you will be supplied with the name and address of the credit agency from which the credit report was received. This will give you the opportunity to correct any errors or disputes on your credit report if any should exist.

**Returned Checks**

Returned checks are subject to a $28.00 fee.

**Dental Insurance**

Treatment recommendations are based on your health, not your insurance. It is your responsibility to be aware of what your insurance benefits are. Our staff will help you understand your insurance benefits. It is important to remember that insurance companies are not concerned about your health and well being- WE ARE. We will provide you with an estimate of insurance benefits, however, it is important to be aware that these estimates of benefits often change and at times are not accurate. You authorize the release of any dental information necessary to process your dental insurance claims. This authorization remains valid until you give written notice that it is explicitly revoked. You are fully responsible for any charges incurred for treatment provided to

you. Your insurance benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not consider “covered expenses”.

**Dental insurance Payments**

You agree to assign, transfer and set over to The Art of Dentistry LLC, all of your rights, title and interest to any dental reimbursement benefits under your insurance carrier for dental services provided by our office. If you dental insurance carrier should send you the payment for the dental services that we provide for you, then you agree to turn over to us that payment within 10 days after you have received such payment. In the event that your insurance company is billed, you authorize payment of dental benefits to be paid directly to The Art of Dentistry, L.L.C.

**Minors**

If you are under the age of 18 at the time services are provided, your parent or legal guardian’s signature below constitutes an agreement and guarantee by your parent or legal guardian that they and you are responsible for paying any and all fees. Your parent or legal guardian’s signature also is an acknowledgement that the services provided are “necessary” dental expenses.

**Infection Control**

Cleanliness and infection control are of the utmost importance. We utilize the latest sterilization technology, including high heat prewashing of all instruments and materials, individually wrapped instrument cassettes, disposable (single patient use) instruments and materials. All of our staff members go through rigorous coursework on a continual basis to ensure that we stick to tough sterilization protocols to ensure your safety. We have also invested in two hospital grade Class B sterilization units, a dental office industry first. Our sterilization protocols and procedures not only meet the accepted OSHA and EPA standards, but exceed them.

**Consent to treatment**

You consent to be treated and represent that all of the foregoing information is true and correct to the best of your knowledge, including the information provided on the Patient Information Form. If any of the above information changes you will immediately notify The Art of Dentistry, L.L.C.

A photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Print Patient Name

_____ _____

Signature of Patient Date

_____ _____

Print Name of Responsible Party Relationship

_____ _____

Signature of Responsible Party Date