AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

Patient or Family members_____

(list of people we may speak with regarding your treatment and care)

_____

_____

ALL FEES, COPAYS AND DEDUCTIBLES DUE AT THE TIME OF SERVICE

Please allow for a copy of your driver's license for our records.
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payer and/or other health practitioner. I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that the filing to my insurance is a courtesy offered to me. I understand that my dental insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I understand that if I do not pay the entire balance within 25 days of the billing date, a finance charge of 20% may be assessed on the unpaid balance. A $10.00 late fee may also be assessed on the tenth of each month. I realize failure to keep this account current may result in Dr. Shunnarah being unable to provide additional dental services except dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

MISSED OR CANCELLED APPOINTMENT POLICY

Should you miss or have to cancel an appointment, you must give a minimum of twenty-four (24) hours notice prior to the cancelled appointment. We reserve the right to charge $30.00 per appointments missed or cancelled with less than twenty-four (24) hours notice. This fee will not be filed on insurance plans and is due upon receipt of billing statement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Noticy of Privacy Practices for my family. Should I need another copy, I understand that I may pick one up at the front desk any time.

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_____ _____

Signature of responsible party Date

Dr. Bobby F. Shunnarah / Montevallo Family Dentistry