Financial Agreement

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This is an agreement between Christopher A. Baker, D.D.S., as creditor, and the Patient/ Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Christopher A. Baker DDS.

By executing this agreement, you are agreeing to pay for services that are received.

Monthly Statement: If you have a balance on your account, we will send you monthly statements. It will show separately the previous balance, any new charges to the account, the finance charge of two percent (2%), and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 11 calendar days of the statement date.

Charges to Account: We shall have the right to cancel your privileges to make charges against your account at any time. Future visits would then need to be paid in cash at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you do not have insurance:

1. You choose to pay by cash, check, or credit card on the day of treatment that is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institution.
3. We offer special financing through Care Credit. Upon approval and depending on the amount charged, you may qualify for interest free financing.

Payment options if you have insurance:

1. If you have insurance, you pay your deductible and any out-of-pocket portions or co-pays at the time services are rendered by cash, check, or credit card.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institution.
3. We offer special financing through Care Credit. Upon approval and depending on the amount charged, you may qualify for interest free financing.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of you eligibility. If your insurance company requires a preauthorization, you are responsible for obtaining it. Failure to obtain the preauthorization may result in a lower payment from the insurance company.

*The Financial Policy continues on the back side of this page.

Patient's Name:_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a preauthorization, you are responsible for obtaining it. Failure to obtain the preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of two percent (2%) per month or an **ANNUAL PERCENTAGE RATE** of twenty-four (24%) percent. The finance charge on your account is computed by applying the periodic rate (2%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account for collection, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all attorney fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Clark County, Indiana.

Returned Checks: There is a fee (currently $30) for any checks returned by the bank.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than one business days notice, a $50 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another dentist.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit agency such as a credit bureau.

Transferring of Records: You will need to make a request in writing if you want to have copies of your records sent to another doctor or organization. If more than one copy is needed, there will be a charge and the amount of the fee is dependent on the number of pages we copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency or bureau, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements must be made before treatment is commenced. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: By signing this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.