SCHOMMER DENTAL FINANCIAL AGREEMENT

This is an agreement between Schommer Dental, P.C., an Iowa Professional Corporation, 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. This includes all fees and services rendered for the treatment of a minor/child for which you are responsible. The words "we," "us," and "our" refer to Schommer Dental, P.C.

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

If you do not have dental insurance, all fees must be paid on the day of service, unless other arrangements have been made prior to the day of service. For patients without insurance, we offer a 5% discount for payment in full by check or cash on the day of service. This does not include debit or credit cards.

I you have dental insurance, all deductibles and co-payments must be paid on the day of service. The same 5% discount applies if payment is made by check or cash on the day of service. You agree to pay all portions of the charges not covered by insurance. This does not include contracted fees between your insurance company and Schommer Dental. The balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one point five percent (1.5%) per month, or an **ANNUAL PERCENTAGE RATE** of eighteen percent (18%).

RETURNED CHECKS: Returned checks for insufficient funds or closed accounts are subject to a $25.00 fee. If a check is returned, cash, credit card or CareCredit will be the only accepted form of payment.

CANCELATION/MISSED APPOINTMENT FEE: If you do not keep a scheduled appointment, or cancel less than 24 hours prior to your appointment, you will incur a $25.00 cancelation fee.

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 to a collection agency, you agree to pay any and all of the collections costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Scott County, Iowa.

 PATIENT INITIALS_____

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

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.

TRANSFERRING OF RECORDS: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to 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 you payment history.

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 you 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 may be discussed. Payment of the account remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

Patient's name_____

Responsible party (if not the patient)_____

Signature:_____ Date:_____