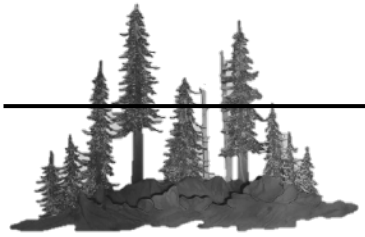

Dr. Mark A. Coussens, DMD

Financial Policy for Our Office

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

** All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our office manager. There will be a 5% discount for accounts paid in full on the day of service. A 7% discount is extended to senior citizens who pay in full on the day of service. Visa and MasterCard are accepted, but no discount will be given as we pay a credit and debit card user fee.

** There will be a $25.00 NSF fee (nonsufficient funds) on all check returned for non-payment.

** On accounts which have established arrangements the payment is due upon receipt of the monthly statement. Any balance outstanding more than 60 days will accrue interest at 1.5% per month, which is 18% per anum.

** Insurance is gladly billed as a courtesy to our patients , when you provide us with current information and any necessary forms. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer and the insurance carrier. YOU are responsible for payment of your account.

** Third party financing is available through Care Credit, if you are interested please ask our office manager.

** We reserve the right to charge for missed appointments with less than 24 hour notice.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

Print Name_____

Signature_____Date_____

* This policy also applies to family members under the age of eighteen if applicable.