Black Creek Dental, LLC
Black Creek, WI

REGISTRATION / AUTHORIZATION AGREEMENT
FINANCIAL POLICY

Thank you for choosing Black Creek Dental, LLC as your dental health care provider. We are committed to giving you treatment with expertise and compassion. Please read the following agreement/policy and sign.

GENERAL CONSENT TO CARE

I understand that my condition requires dental care. I voluntarily consent to services provided by Black Creek Dental, LLC, including routine diagnostic procedures and dental treatment ordered by the dentist providing services to me.

RELEASE OF INFORMATION FOR PAYMENT OF ACCOUNT

I agree that Black Creek Dental, LLC and its dentists participation in my treatment may release to my insurers, other payers or other persons as necessary, for billing and related purposes, any information which may be needed for the purpose of billing, collection of payment of claims for services provided.

RELEASE OF INFORMATION TO OTHER HEALTH CARD PROVIDERS

I agree that Black Creek Dental, LLC and its dentists participation in my treatment may release my dental information to other health care providers or health care facilities they have referred me to for additional treatment. The information released will be pertinent to the diagnosis/condition for which I have been referred.

ACCESS TO HEALTH CARE RECORDS

Upon submitting a statement of informed consent to release my confidential dental information, either myself or a person authorized by me may:

* Inspect my health care records during regular business hours, upon prior notice.
* Receive a copy of my records upon a payment of reasonable costs.
* Have my x-rays referred to another health care provider of my choice.

ASSIGNMENT AND FINANCIAL AGREEMENT

In regard to services rendered by Black Creek Dental, LLC and its dentists, I irrevocably assign to Black Creek Dental, LLC and its dentists any insurance benefits due covering incurred expenses. I agree that, should the amount be insufficient to cover the entire expense. I will be responsible for the payment of the difference. If he care is determined to be a non-covered benefit not covered by insurance, I will be responsible to Black Creek Dental, LLC and its dentists for payment of the entire bill. (Your insurance policy is a contract between you and your insurance company. We are not a party to that contract). I future authorize billing statements to be sent to the person that I designate on my patient registration, or this form, as my responsible party including but not limited to my spouse.

WORKER'S COMPENSATION CLAIMS

In the event of a Worker's Compensation claim, I understand that all dental/medical information will be furnished to the carrier and / or employer with or without written consent from the patient according to the Wisconsin Worker's Compensation Action, Sec 102.12(2). I further understand that my opinion and/or dentist's diagnosis does not necessarily assure payment of my claim by the Worker's Compensation. Should Worker's Compensation deny my claim, I agree to be financially responsible for all charges incurred for my care.

AUTOMOBILE ACCIDENT/PERSONAL INJURY CLAIMS

In the event of any automobile accident or personal injury claim, I understand that all medical information will be furnished to the carrier with or without written consent form the patient according to the Personal Health Release Guidelines. I further understand that my opinion and / or the dentist's diagnosis does not necessarily assure payment of my claims by the carrier. Should the carrier deny my claims, I agree to pay all charges incurred at Black Creek Dental, LLC. IF I decide to dispute the decision of the carrier, I agree to make good faith payments each month while I pursue this claim.

We accept Cash, Checks (from established patients ONLY), and Major credit cards VISA/MASTERCARD.

PAYMENTS ARE DUE ON ALL ACCOUNTS AT BLACK CREEK DENTAL, LLC <u>EVERY</u> 30 DAYS.

A service fee of 1.5% interest per month will be assessed, from the date of service, to all accounts that are delinquent for more that 35 days. A monthly billing charge may also be applied to all accounts that are delinquent.

Patient Name (Please print): _____

Last First MI

Patient Date of Birth _____

Patient Signature: _____ Date: _____

Person (other than self) authorized to receive health and financial information:

Name: _____

This agreement is to include all family members as listed on your account.

Name: _____ relationship: _____

Name: _____ relationship: _____

Name: _____ relationship: _____

Name: _____ relationship: _____

IF YOU WISH TO SET UP A BUDGET PLAN TO FIT YOUR INDIVIDUAL NEEDS, YOU MUST CONTACT OUR OFFICE WITHIN 30 DAYS OF <u>FIRST</u> BILLING STATEMENT.