Joan H. Lynch, D.D.S.
Leanne B. Sullivan, D.M.D.

Please read this statement prior to our agreement to perform dental treatment on you and/or agree to file your claims to your insurance company. This will avoid any confusion about our policies, as well as any misunderstandings on the processing of your claim(s). If you have any further questions, please ask our front office personnel.

* I understand and agree that I am responsible for payment of all treatment fees at the time that services are rendered. If I have any doubt in my ability to pay for my appointment, I will coordinate a payment arrangement with the financial coordinator prior to my appointment. I understand that no arrangement will last for longer than 90 days in house. I understand that my account may be turned over to a collection agency at the end of 90 days if I still have a balance caused from my inability to make my payments.

* If I have dental insurance, I understand and agree that I am responsible for the estimated amount not covered by my insurance carrier on the date that the service is provided. I understand that after my insurance pays Dr. Lynch / Dr. Sullivan, there could still be a balance remaining, for which I am responsible for payment in full at that time.

* I understand and agree that I am responsible for payment of all treatment fees on my account if my insurance carrier fails to pay within 60 DAYS, I will be responsible for the FULL amount owed to Dr. Lynch / Dr. Sullivan.

* I understand and agree that if the estimated portion indicates a large amount due by me, I have the option of paying by Visa, MasterCard, Cash, Check, CareCredit, or to apply for a loan.

* I also understand and agree that if I need to change my appointment time, I will do so at least 24 hours in advance to avoid a $55 cancellation fee.

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Signature of responsible party

____
Office Manager

____
Date

5713 GRAY ROAD
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FAX (813) 973-1738