SEDRO-WOOLLEY FAMILY DENTAL CENTER'S CERTIFICATION AND FINANCIAL STATEMENT

CERTIFICATION

To the best of my knowledge, the information I have provided on my registration forms is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of filling out my registration forms and I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

INSURANCE ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s), have insurance coverage, all insurance benefits, if any, otherwise payable to me for services rendered will be directly assigned to Sedro-Woolley Family Dental Center. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I authorize the use of my signature on all insurance submissions.

Sedro-Woolley Family Dental Center may use my health care information and may disclose such information to the Insurance Company(ies) (if applicable) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

FAILED APPOINTMENT/ LAST MINUTE CANCELLATIONS

I understand that I will be charged for any failed appointments or last minute cancellations if I do not give 24 hours notice. It is Sedro-Woolley Family Dental Center's office policy to charge $85.00 for any failed appointments or last minute cancellations.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal represenatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. *I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.*

Service Charge:

A service charge of 1% per month on all balances of thirty days or greater, with a minimum $1.20 late charge, will be assessed on your account.

Venue:

In case a legal action is commenced to collect this account, at the request of either party, venue for any legal action shall be placed in Skagit County, WA.

Reasonable Attorney's Fees:

If this account is not paid as agreed, and legal action is commenced to collect the amount due, I (we) agree that, in addition to other charges authorized herein, we will pay reasonable attorney's fees.

I have read and agree to the.above financial statement.

_____ _____

Signature of Patient or Guardian *Date*

_____

Please print name of Patient or Guardian

RELATIONSHIP TO PATIENT (CIRCLE ONE)

Self Spouse Parent Step-Parent Foster-Parent Other _____

Explain