LAKE OSWEGO FAMILY DENTISTRY, LLC
FINANCIAL POLICY and PAYMENT AGREEMENT

1. **Policy**. You will be charged whenever you receive care. All payments, including co-pays, are due and payable in full at the time of service. If we both agree that you will pay for a service in installments, you will pay the remaining balance in accordance with this agreement.

2. **Prior Payments**. Payments made before receiving care will be credited against your account. After applying prior payments to your account, you will pay any remaining balance in accordance with this agreement.

3. **Estimated Amount**. You agree to pay to us $_____.___ (Estimated Sum). This is an estimate. Other charges may be incurred and, if your insurance changes, the Estimated Sum may change.

4. **Payments Due**. If we both agree that you will pay in installments, as explained above, you will pay the balance in _____ equal monthly installments, payable on or before the _____ day of each month, beginning on the _____ day of the following month in which the charge is incurred. The payments will continue until the balance is paid in full. If we agree to accept more than four payments we will provide you with a Truth In Lending Disclosure Statement.

5. **Additional Charges**. If, prior to paying in full any remaining balance, you incur additional charges, they are due in full at the time of service, as explained above. If we both agree that the additional charges may be paid in installments, you must sign a new Financial Policy and Payment Agreement.

6. **Pre-payments**. You may prepay any or all of the unpaid balance without penalty. However, a partial prepayment does not excuse the obligation to make any payment required under this agreement.

7. **Finance Charges/Late Payments**. Any balance outstanding after 60 days will accrue interest at the rate of 1.5% per month (18% annually). Additionally, the entire balance may be sent to a collection agency and may result in denial of further treatment by us.

8. **Co-payments**. Any co-payments, deductibles, or co-insurance required by an insurance company, as well as payment for non-covered services must be paid at the time of service.

9. **Cancellations**. Any appointment cancelled without 48 hours' notice will result in a late cancellation/no show fee.

10. **Returned Checks**. A fee (currently $25) will be charged for any checks returned by the bank for insufficient funds. ORS 30.701.

11. **Identity Theft Protection**. We will take appropriate measures to verify patient identity and contact information.

12. **Insurance**. Your insurance coverage is a contract between you and your insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill

both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of our charges not covered by insurance. As a courtesy, we allow 60 days for insurance payment to be received. If your insurance company has not made payment to our office within 60 days, you will then be responsible for any existing balance.

13. **Minor Children**. Charges for minor children will be billed to the parent with whom the child resides, or to appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

14. **Attorney Fees**. In the event we must consult an attorney or commence any legal proceeding to interpret or enforce any provision of this agreement, or to collect any amount owing under this agreement, we will be entitled to recover reasonable attorney fees, including the cost of appeal, in addition to the costs and disbursements allowed by law. You will be entitled to recover your reasonable attorney fees from us should you prevail. The amount of the fee will include an amount estimated by the court as the reasonable costs and fees to be incurred by the prevailing party in collecting any monetary judgment or award or otherwise enforcing any order, judgment, or decree entered in a suit or action.

15. **Notice to Patient/Debtor**. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT YOU SIGN. KEEP THIS AGREEMENT TO PROTECT YOUR LEGAL RIGHTS.

_____ _____

Date You

_____

Patient's Name (if different)