

J. MATTHEW HOGENDOBLER, D.M.D.

LINKHORN POINT PROFESSIONAL CENTER

1729 Wildwood Drive, Suite 104

Virginia Beach, Virginia 23454

AUTHORITY TO TREAT

I apply for treatment by and grant authority to treat to **J. MATTHEW HOGENDOBLER, D.M.D.**, hereinafter referred to as **Provider**, its associates, hygienists and/or assistants, to administer any treatment, which may include radiographs, anesthetics, injections, the prescribing or administration of medications and/or the performance of any procedures or operations which may be deemed necessary for the diagnosis and treatment of my case. I agree to disclose a complete medical-social history, including any changes which occur either during the course of treatment or during the time I am a patient of record with Provider. I understand the provisions of **Informed Consent** whereby I may decline any treatment, procedure or operation recommended by Provider and, in so doing, release Provider from any liability resulting as a consequence of any failure on my part to disclose requested information, or any decision I may now or at any time in the future elect to make regarding either non-treatment or non-disclosure. I recognize the importance of maintenance, recall or other additional office visits and hereby absolve Provider of any and all responsibility for failure in diagnosis, service or treatment if I fail to return to Provider according to the schedule assigned me at each office visit.

RELEASE OF INFORMATION

I authorize the general release of information necessary, either for the consultation or conferring of treatment with another provider, the referral of my case to another provider or specialist, collection agency, attorney or laboratory or for filing of any insurance claims on my behalf for any amounts which may be due my account by my carriers. I further understand that I may be required to sign a "Release of Information" form for any specific information requested to be sent or received from Provider.

DESIGNATION OF RESPONSIBLE PARTY

If **Responsible Party** is other than **Patient** named below, I represent and acknowledge by signature below that I am Patient's legal or natural Responsible Party (*parent, guardian, &c.*) and accept *full* responsibility for Patient's payment and for any decision I may make regarding Patient's treatment by and financial obligations to Provider. I further realize I remain responsible for same up to and including the date I advise Provider in writing that my designation as Responsible Party changes.

TERMS OF PAYMENT

For goods and services received from Provider, I accept the following payment terms and conditions:

- Payment may be made by cash, local personal check, insurance check, money order or credit card (*Visa, MasterCard, American Express or DiscoverCard*);
- All emergencies and first appointments are due and payable in full upon completion of in-office visit, without regard to insurance benefits coverage;
- For existing patients of record with account balances
 - < \$300, payment in full is due and payable upon completion of in-office visit;
 - \$300-750, payment in full is due upon completion of in-office visit or upon receipt of statement generated at the end of the month (*net 30 days*);
 - > \$750, payment in full is due upon completion of in-office visit(s), upon receipt of statement (*net 30 days*) or according to the **Policy of Credit**;
- For retirement facility, in-home, hospital or other outpatient services, balance in full is due and payable upon receipt of first statement (*net 30 days*) or, if charges exceed \$750, according to terms offered above.

POLICY OF CREDIT

Because this is an application for credit, I authorize Provider to access my credit history using the Social Security Number(s) below. Unless other payment arrangements are made with Provider in order to finance dental treatment (*ie. CareCredit®*), extensions of credit by Provider, including any and all unpaid account balances, shall be at the discretion of Provider and governed by the following exclusions and limitations, conditions and terms specifically assigned to the undersigned Responsible Party:

- A. Financing is available for up to three (3) months only, the monthly balance of which shall be subject to a 1.84% monthly finance charge (*22.08% APR*);
- B. Balance-in-Progress payments, when fees for specific treatment visits exceed \$750, may be financed independently upon approval of Provider as follows:
 1. Two (2) equal payments during the course of specific treatment:
 - a. One half (1/2) payable in full upon completion of initial treatment (*impressions for crown, denture, initiation of root canal, &c.*);
 - b. One half (1/2) payable in full upon completion of final treatment, including finance charges (*insertion of crown or denture, &c.*);
 2. Three (3) equal payments during the course of specific treatment:
 - a. One third (1/3) payable in full upon completion of initial treatment;
 - b. One third (1/3) payable in full upon completion of mid- or final treatment;
 - c. One third (1/3) payable in full upon completion of final treatment, upon receipt of statement (*net 30 days*), or according to "A" above;
- C. Proof of identification with photograph and concurrent account with a Tidewater/Hampton Roads banking institution, both maintained while patient of record;
- D. Notification to Provider within thirty (30) days of any and all changes in Responsible Party's name, address, designation, identification or banking information which occur during the period of repayment or credit;
- E. If payment(s) are not made when due and payable according to Terms of Payment and Policy of Credit above, I agree to pay *all* costs of collecting unpaid balances, including filing fees, finance charges, late fees and any and all costs associated with the employment of collection agencies or attorneys. I further understand that, in the event my account is referred to an agency or attorney for collection, I shall, in addition to all other charges, be liable for collection agency and attorney's fees of up to 40% of the balance due at the time of referral, plus court costs and all other costs incurred in collecting on my account;
- F. I agree to pay \$35 for any check not honored for any reason, in which case I forfeit the right to present checks to Provider as a future form of payment.

STATEMENT OF INSURANCE

I agree to notify Provider if I am insured by a policy which provides benefits for dental treatment, if such coverage lapses or terminates for any reason, or if my insurance carrier changes while I remain a patient of record with Provider. I understand that my financial responsibility extends to the total charge without regard to any potential insurance benefits, and that any insurance benefits which may be provided by my insurance carrier(s) will be considered a part of my financial resources only and will not waive my responsibility for payment. I agree that, upon completion of each visit, all pre-estimates and actual copayments and deductibles are due and payable according to Terms of Payment and Policy of Credit above. I recognize that insurance agreements exist between patients and their carriers, and I waive any and all expectations of Provider to intercede on my behalf in the resolution of disputes or appeals with my carrier(s).

I, the undersigned Responsible Party, have read, accept and fully understand the meaning and consequences of the above statements.

For Office Use Only

Name of Patient (*Printed*)

Name of Responsible Party/Relationship (*Printed*)

Responsible Party Social Security Number

Patient's Social Security Number

Signature of Patient's Responsible Party

Date