Nina V. Aks, D.M.D.
General, Cosmetic & Implant Dentistry

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FINANCIAL POLICY

This is an agreement between Dr. Nina V. Aks, D.M.D. as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," "yours," mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Nina V. Aks, D.M.D., L.L.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Statement: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, the finance charge (if any), and any payments or credits applied to your account during this month.

Payment options:

- You can choose to pay on the day that treatment is rendered.
- On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance in three weeks.
- On extensive treatment, you may have an arrangement to make monthly payments on your account by providing us predated checks for the full amount you owe.
  (This option is available only for patients with good credit history).
- You can pay by Visa, Master Card, cash, or check.
  We appreciate your payment by **cash** or **check**. Any credit/debit card transactions done in our office in the amount of $500 or more will be assessed a **3%** transaction fee to cover merchant fees. Making a payment by phone with a credit/debit card for ANY size balance may incur the same 3% transaction fee.

Insurance is a contract between you and your insurance company. We are NOT a party in this contract. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining those.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of a statement month.

Required Payments: Any co-payments must be paid at the time of service.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

Returned checks: There is a fee (currently $35) for any checks returned by the bank.

Cancellations and broken appointments: Please remember that missed appointments will affect the length and possibly the success of your treatment. If you are unable to keep your appointment, please notify us at the earliest possible time. This courtesy on your part makes your appointment available to another patient who is waiting to be seen. **Doctor appointments missed or canceled with less than 24 hours notice will incur a charge of $170.00. Hygiene appointments missed or canceled with less than 24 hours notice will incur a $60.00 missed appointment fee.**

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history.

Workers compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Patient's name:_____ Responsible party (if not the patient):_____

Signature: _____Date: _____