John T Webster, DDS, Inc.

36701 American Way, Suite 1
Avon, Ohio 44011

Financial Policy

Thank you for choosing us as your dental health provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In order to keep fee increases to a minimum and continue to provide the best quality care for our patients, we now ask that patients pay for their treatment with one of the following options at the time of service:

- Cash
- Check
- Credit Card – *Visa, MasterCard, Discover*
- Care Credit or Citi Health Card- *Extended payment plans*

Patients with Dental Insurance: We will continue to submit your insurance. However, we ask that you pay your insurance co-payment at the time of service. Insurance co-payments may change according to the procedures performed and your policy that you have with your employer. We cannot be responsible for services not covered or balances that have not been paid by your insurance. **Legally you are responsible for your account regardless of your balance. Please be certain of your commitment to our office prior to starting any dental treatment**.

Preventative- co-payment is contingent upon individual policies per your employer.
Basic-20% is required.
Major-1/3 of total is required.

Note: Any insurance plan that pays directly to the patient requires payment in full at the time of service, unless prior financial arrangements have been made.

If your Insurance Company fails to pay in 45 days we are left with no option but to turn over the balance to you for payment. Any further follow up for reimbursement to the insurance company will be your responsibility. _____Initial

Truth & Lending: Late charges or finance charges will be assessed if payment is not received by the 20th of each month. The amount of the late charge is a minimum of $5.00 with a maximum of $20.00. Finance charges are assessed on all accounts with balances not paid within 90 days at a rate of 1.25%.

We appreciate your understanding of this our policy. We look forward to continuing to serve you and your family's dental health needs.

John T Webster, DDS

Appointments are reserved especially for you. Kindly give our office a 48 hour notice if you need to reschedule or cancel. A $50.00 broken appointment or late cancellation fee will be considered if less than a 48 hour notice is not given. _____Initial

There will be a $35.00 charge for all returned checks._____Initial

_____ _____
Responsible Party or Legal Guardian Date

ACCOUNT INFO
ACCOUNT NO.: 130101

PATIENT NAME: _____

ACCOUNT NAME: _____

TRUTH IN LENDING
Explanation of Late Charges and Finance Charges

LATE CHARGE: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late charge to be assessed is the maximum amount authorized under the laws of the state of Ohio. The late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $20.00.
FINANCE CHARGE: A **finance charge** is imposed on those charges not paid in full within 90 days of the date you were first billed for the charges. The balance on which any **finance charge** is computed is determined by totaling the charges not paid within the time period shown above and on the front of your billing statement.
The **finance charge** is a periodic rate of 1.25% per month. The **finance charge** is computed by multiplying the balance on which the **finance charge** is computed by the periodic rate shown above. There is a $1.00 minimum **finance charge.**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you thin you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights.
In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

_____
Dental Entity Name

A photo copy of this document may act as an original.

_____ _____
Signature of Insured Date