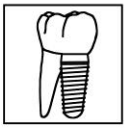

Samir F. Zakaria, D.D.S., M.S.D.
Periodontics & Dental Implants
Diplomate, American Board of Periodontology

Financial Policy

Printed Patient Name _____ Date of Birth _____ Chart Number _____

Thank you for choosing our practice. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

The patient's portion of payment, as well as any past due balances, is due at the time services are rendered unless prior arrangements have been made. We accept cash, personal checks, Master Card, Visa, Discover, American Express and Care Credit. If you wish to be billed, there will be a $10 charge added to your office visit charge(s).

It is YOUR responsibility to check which services are covered under your insurance plan;
However, you must understand that:

1. Your insurance policy is a contact between you, your employer, and the insurance company. Our relationship is with YOU, not with your insurance carrier.
2. All charges are YOUR responsibility whether your insurance company pays or not.
3. Fees for service, co-payments and unpaid deductibles are due at the time of service. See paragraph 2 above.
4. If the insurance company does not pay our balance within 60 days, we may ask you to contact them to request prompt payment. Please inform US of their response.
5. Billed balances over 30 days will be charged a **1.5% rebilling fee.**
   Billed balances over 60 days will again be a charge of **1.5% rebilling fee**.
6. Billed unpaid **balances over 90 days are subject to a $30.00 collection** fee and will be sent to small claims court, an attorney, and/or Collection Agency.*
7. Returned checks are subject to a **$35 collection charge**; we will notify you by mail. If your outstanding balance is not paid within 10 days, it may be subject to formal collection action as detailed above.

* We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Authorization to Release and Assign Benefits: I authorize release of any information required to act on any Insurance Claim and permit photographic, electronic or other facsimile reproduction of the authorization to be used in place of original assignment. I herby assign to Samir F. Zakaria, DDS, MSD the dental benefits I am entitled from my insurance company. The authorization is in effect for all future claims, until I choose to revoke it in writing.

I understand that I am financially responsible for all charges incurred as described above. I, the undersigned, understand and agree to be bound by the Financial Policy.

_____
Patient's Signature (or Parent/Guardian is Patient is a Minor) Date

_____
Signatory's Printed Name Relationship to Patient