

West End Smiles, PLC
Ivana K. Hrstic, D.D.S.
General and Cosmetic Dentistry

PATIENT RESPONSIBILITY
OFFICE FINANCIAL POLICY

I understand that I am responsible for all fees related to my dental care and treatment.

I understand that full payment for all dental treatment is to be paid at the time the treatment is performed unless prior financial arrangements have been made.

I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to West End Smiles, PLC or Dr. Ivana K. Hrstic for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument of electronic authorization is later honored, I will be charged the maximum allowable service charge.

I understand that if my account is not paid, my account may be turned over to a collection agency. In addition to paying my balance, I agree to pay all reasonable attorney's fees, collection and/or court costs, and a monthly interest charge at applicable maximum legal rate.

I understand that unless patient records are sent to another provider, the charge for copies of x-rays and treatment information is currently \$20.00. These fees are subject to change without notice.

BROKEN AND/OR MISSED APPOINTMENTS

West End Smiles, PLC reserves the right to charge a fee of \$25.00 for any appointment not kept by the patient. After two(2) broken appointments, the dentist retains the right to discontinue elective treatment.

PATIENTS WITH DENTAL INSURANCE

I understand that my insurance policy is a contract between myself and my insurance company. West End Smiles, PLC and/or Dr. Ivana K. Hrstic, affiliates, and employees are not parties to my contract with the insurance company.

I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay balance and later does not.

I understand that I have the option of only paying my estimates portion (that portion not covered by insurance) at the time of service. As a courtesy, the office will send my claim to my insurance company. If my insurance company fails to pay balance, the balance is my responsibility and payment is due in full.

I understand that full payment for all dental treatment is to be paid at the time the treatment is performed. Any balance left unpaid could be turned over to a collection agency and any collection fees in addition to my balance would be my responsibility.

I have read, understand and agree to the above Office Financial Policy.

NECESSARY X-RAYS AND TREATMENT

I understand that for proper diagnosis and treatment x-rays are required.

I understand that there can be change in treatment due to conditions found during procedure and alternate treatment may be necessary therefore estimated costs could change.

Signature of Patient, Parent of Guardian

Date

Financing is available