Financial Agreement

I agree to pay Laser and Cosmetic Dentistry of Delray FOR PROFESSIONAL SERVICES RENDERED, OR TO BE RENDERED, at the time the service is performed unless other arrangements have been made in advance. I understand that any balance past due over 30 days from the first billing date will be subject to an interest charge of 1.5% per month (18% annual rate) if I elect not to pay within 30 days.

I also understand that insurance benefits assigned to Laser and Cosmetic Dentistry of Delray must be paid within 60 days from the date of insurance billing. If insurance has not been paid within 60 days, I agree to pay Laser and Cosmetic Dentistry of Delray the full balance. Any payment received by Laser and Cosmetic Dentistry of Delray after my balance has been paid **will be refunded to me**. I understand that Laser and Cosmetic Dentistry of Delray cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I understand I am ultimately responsible for this account no matter what my insurance may or may not pay.

I agree to give 24 hours notice if I need to change my appointment.

I understand that fee estimates quoted are based on all appointments being kept. The fee will be higher if there are frequent short notice cancellations or appointment changes. Fees quoted will remain valid for 90 days.

I understand that if necessary for Laser and Cosmetic Dentistry of Delray to retain the services of an attorney to collect my unpaid balance, I will be responsible for all court costs, attorney fees and any other collection fees which may be incurred as a result of my account being turned over for collections as allowed by the state of Florida.

I agree to pay a fee of $25.00 for a check returned N.S.F.

I have read and understand the above agreement

_____ _____

Signature of patient or guardian Date

Acknowledgment Of Fee For Broken Appointments

I, _____, understand and acknowledge that the appointments I make with the Doctor(s) and or Hygienists are set aside specifically for me, and that it is my responsibility to Laser and Cosmetic Dentistry of Delray, Inc. **at least 24 hours advance** if I must cancel my appointment.

I understand that if I do not give proper notice to cancel my appointment, or that if I fail to show up for a scheduled appointment without notice, I will be charged a "broken appointment" fee. That fee is $30.00 per fifteen minutes of reserved appointment time, or the **maximum allowed by my dental plan**. I agree that this fee is reasonable in light of the cost to the office incurred when patients cancel without proper notice.

X_____

Patient Signature or Guardian

_____

Date

Photographic Release (optional)

I_____, hereby authorize Laser and Cosmetic Dentistry of Delray to take photographs and slides of my face, jaws, and teeth. I understand that the photographs and slides will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising and in publications. I waive compensation, financial or otherwise, for the use of the photographs or slides.

Patient or Guardian Signature:_____ Date:_____

Laser and Cosmetic Dentistry of Delray

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize Laser and Cosmetic Dentistry of Delray, Inc., Dr. Antonio Festa and Dr. Alain Pouleriguen (the "Practice") to disclose my entire medical records (or the medical record of _____) in accordance with the Laser and Cosmetic Dentistry of Delray Inc. Notice of Privacy Practices for treatment, payment and healthcare operations purposes. I have reviewed the Notice of Privacy Practices, been given the opportunity to ask questions about it, understand and do hereby agree to the terms. I understand that the Practice may amend its Notice at any time and that I am entitled to receive a current copy of the Notice of Privacy Practices by requesting on at the front desk, or by contacting the Practice's privacy officer, Donna M. DiChiara, Esquire at 954.725.3717.

I understand that I can revoke this Consent in writing at any time, except to the extent the Practice has already taken action relying upon it.

By: _____(Patient or representative's signature

_____(Print name)

Date:_____

FOR OFFICE USE ONLY: