SMILES ON ELSTON

PAYMENT ARRANGEMENT FORM

PATIENT NAME ("patient")

PAYMENT AGREEMENT I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to *Smiles on Elston* at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while *Smiles on Elston* will file claims with my insurance company on my behalf, I remain responsible to *Smiles on Elston* for what is not paid by my insurance company. I also understand that if *Smiles on Elston* cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that *Smiles on Elston* may charge:

1) a late fee if payment on my account is not received by the due date;

2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and

3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to *Smiles on Elston*.

RESPONSIBLE PARTY:

Full Name _____ DOB _____ SS# _____

Street Address_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer Name _____

INSURANCE INFORMATION:

PRIMARY INSURANCE:

Primary Insurance Name _____ Address_____ Phone Number_____

Name of Insured _____ Relationship _____ID Number_____ Group Number_____

SECONDARY INSURANCE:

Secondary Insurance Name _____ Address_____ Phone Number_____

Name of Insured _____ Relationship _____ID Number_____ Group Number_____

I acknowledge having received a copy of Smiles on Elston's Notice of Privacy Practices. *I agree that a photocopy of this authorization is as valid as the original.*

Location where this agreement was signed: Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646

*Signature of Responsible Party*_____ *Date* _____

(to be signed even if Patient is also the Responsible Party)