Health Information Request Fees

I understand that I have the right to request that the office provides copies of my health information. To do so, I must make a request in writing listing the information I wish to receive. I agree to a reasonable cost based fee for expenses of $30 per person. There is no charge for electronic email transfers.

X _____

Signature of patient or parent if minor Date

Late Charges

I understand if I do not pay the entire new balance within 90 days of the monthly billing date, I agree to pay various late charges. The charges are as follows: a collection fee of an additional 35% of balance, an attorney fee (if necessary) of an additional 55% of balance, and a court cost (if necessary) of $75.00. In the case of a returned check, I also agree to pay a $25 returned check fee. I also realize that failure to keep this account current may result in the doctor being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services.

X_____

Signature of patient or parent if minor Date