PATIENT RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by the Plymouth Meeting Dental Associates (also called the "Dental Office"), according to the policies stated in this Patient Responsibility Agreement.

PATIENT INFORMATION. The patient information I provided to the Dental Office is true and correct. I will notify the Dental Office about any significant future revisions to the patient information furnished.

INSURANCE. The Dental Office will submit insurance claims as a courtesy to me. I am directly responsible to the Dental Office for my account regardless of my insurance benefit payments. If any insurance claims are outstanding in excess of 60 days, I may be responsible for payment in full. If later insurance benefits are paid, the Dental Office will return them to me. If my insurance does not reimburse the Dental Office, **charges are due at the time treatment is rendered.**

PAYMENT SCHEDULE. Unless my treatment is scheduled over a period of time, and unless I specifically request, and the Dental Office approves in advance, a payment schedule for the patient services, **all payments for services are due at the time treatment is rendered**. We accept cash, checks and credit cards. For extended payments we suggest Care Credit. They offer long-term payment plans, including interest free options.

BILLING STATEMENT. After receipt of insurance payment, I agree to pay the full balance within 10 days of receipt of the billing statement.

REFERRAL FOR COLLECTION. If after 90 days, my account is referred to an outside agency or attorney for collection, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The Dental Office may deny subsequent patient treatment if my account balance remains unpaid.

ACCOUNT CHARGES. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1 1/2% per month (18% annually).

FAMILY RESPONSIBILITY. I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my family members, regardless of ages, unless I notify the Dental Office in writing otherwise.

CANCELED APPOINTMENTS. If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of $50.00.

RETURNED CHECKS. If my check is returned by the bank, I can be assessed with a processing charge of $30.00.

Dated: _____ _____

Patient or Responsible Party Signature

Plymouth Meeting Dental Associates

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, _____, acknowledge that Plymouth Meeting Dental Associates' Notice of Privacy Practices has been available to me.

Please Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify): _____

_____