

Don M Newman, D.D.S., P.C.

WEST OFFICE

3945 Eagle Creek Parkway / Suite A
Indianapolis, IN 46254
Phone: 317-293-3000
Fax: 317-293-6773

NORTH OFFICE

10425 Commerce Drive / Suite 130
Carmel, IN 46032
Phone: 317-803-3300
Fax: 317-803-3300

FINANCIAL RESPONSIBILITY AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstanding can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. You are responsible for payment of bill not paid by your insurance.

For your convenience, our office has made arrangements with Care Credit to offer low monthly payments with no annual fee. Check with our front office staff for details.

We believe our fees give excellent value for the high quality of service we provide. What insurance company's call "Usual and Customary" vary with the dental plans offered by your employer and which plan the employee selects.

Payment is due and payable as services are rendered.

(Please indicate the manner in which you wish to handle your account.)

- _____ 1. I will pay in full the date of service/treatment by check, cash, credit card, debit card, or Care Credit.
- _____ 2. I have insurance and agree to pay my estimated portion the day of service/ treatment by check, cash, credit card, debit card or Care Credit.

Applications are available at front office for Care Credit_____ I would like to apply.

Prepayment Courtesy: A 5% courtesy will be given if total treatment (\$500 minimum) is paid at time of treatment or prepaid before scheduled appointment by check, cash, debit or credit card. (excluding Care Credit)

Interest: We reserve the right to charge interest in the amount of 1.5% per month as provided by state law or a billing fee of \$5.00 on accounts 30days or older.

Missed Appointments: We require 24-hour advance notice. A minimum charge of \$50.00 is made for missing a scheduled appointment without advanced notice.

In consideration of treatment required, I accept full financial responsibility. Insurance forms will be completed as a courtesy to the patient; however, your estimated payment not covered by insurance is expected on the date of services rendered, unless prior arrangements are made. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection fees, attorney fees, and interest and court costs. I also agree to assign any/all insurance benefits to be paid directly to Don M Newman DDS PC.

I have read this Financial Agreement. I understand and agree to this Financial Agreement

X _____ Date _____
Signature of Patient or Responsible Party