ANN HAMMI BLUE, DDS, MS, PC

FINANCIAL RESPONSIBILITY AGREEMENT

The treatment plan options(s) have been explained to me. I understand that I am personally responsible for complete payment of all services, treatments, and products at the time dental services are rendered, unless financial arrangements have been made prior to treatment. I acknowledge that I have been advised that the dental treatment plan I have received may not be a covered benefit under my dental care program, and if I elect to proceed with this treatment I agree to be personally responsible for all costs not covered by my dental insurance provider. I further understand that this is only an estimate; the doctor may deem additional procedures necessary during treatment, and that I am responsible for any additional costs.

I hereby authorize payment directly to Dr. Ann Hammi Blue for dental benefits, if any, for any services provided. I further understand that any co-payments or monies paid toward dental treatment/procedures performed is **only an estimate**, and the actual amount owed will be determined at the time dental insurance claim payments have been paid in full.

In the event of default on my behalf of this agreement, I agree to pay interest, legal fees, collection costs, and attorney fees incurred as a result of non-payment. I understand that if the entire balance on my account is not paid in full within thirty (30) days after receipt of notification of delinquency, finance charges will be assessed.

I understand that if it is my responsibility to update my records with Dr. Ann Hammi Blue's office in the event of any address, phone numbers, or insurance changes as soon as possible.

I also agree that I will provide the office of Dr. Ann Hammi Blue with at least forty-eight (48) business hours **prior** to my scheduled appointment of any cancellations or reschedules. I understand I will be charged a fee of $200.00 for a cancellation/no show of a surgical appointment, and $100.00 for a cancellation/no show of a non-surgical appointment without at least forty-eight (48) business hours notification.

I hereby authorize the office of Dr. Ann Hammi Blue to release any information acquired in the course of examination or treatment to my insurance carrier or other dental/medical professionals.

_____

Patient / Guardian Signature

_____

Date