Farrow Pediatric Dentistry Financial Policy

Responsible Party Agreement

I, (print, responsible party name)____

do, on (Day) ________________ of (Month) ________________________________ (Year) _________________

acknowledge and/or accept FULL financial responsibility, regardless of any/all Insurance payments, for

(print patient's name)____

I understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. I understand that, where appropriate, credit bureau reports may be obtained. I understand that though good results are expected, the possibility and nature of complications cannot be accurately anticipated, therefore, no guarantee as to the result of treatment can be made.

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Tennessee and any other State.

I, the undersigned, agree, in order for us to service your account or to collect monies you may owe, Farrow Pediatric Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Farrow Pediatric Dentistry, its employees and/or agents may contact me/us as described above.

Sign below:

Responsible Party Signature: ____ Date: ____________

____Date: ____________

Responsible Party Printed Name: ____

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REVISED Jan. 2012