FINANCIAL POLICY

Jack P. Campbell, P.A.
(904) 264-9096

1700 Wells Road #19
Orange Park, Fl 32073

-This is an agreement between Jack P. Campbell, DMD, as creditor, and the Patient/Debtor named on this form.

-In this agreement, the words "I," "my," "me," "you," and "yours," mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Jack P. Campbell, DMD.

-**Payment is due when services are rendered.**

-We accept Cash, Money Order, Personal Check, MasterCard, Visa, or CareCredit.

-I understand there will be a returned check charge added to the balance due for any returned checks. In the event that my check is returned, the only payment options available are Cash, Money Order, MasterCard, Visa, or CareCredit

-I understand, regardless of insurance coverage, I am responsible for all charges incurred for services rendered, and if my insurance carrier pays less than Dr. Campbell's fee for service, it is my responsibility to pay the difference.

-I understand that it is not the responsiblilty of Dr. Campbell's office to file my insurance. However, the office will file insurance as a courtesy to me, the patient.

-I understand that if I only receive an evaluation, full payment is due at the time of service. If I have insurance, Dr. Campbell's office will gladly file for me, and request benefits to be paid to me directly.

-I understand that if treatment is necessary, and my insurance company will pay Dr. Campbell directly, my estimated co-payment is due at the time of service.

-I understand that if treatment is necessary, and I have no insurance coverage, or my insurance does not pay Dr. Campbell directly, payment is due at the time service is rendered. Dr. Campbell's office files insurance for me, the patient, even if it does not pay him directly.

-A finance charge will be applied to all overdue accounts.

-I understand that if I do not have insurance, or my insurance does not pay Dr. Campbell directly, a 10% (ten percent) finance charge will be applied to the remaining balance at 60 (sixty) days past the treatment completion date.

-I understand that if my insurance company pays Dr. Campbell directly, a 10% (ten percent) finance charge will be applied to the remaining balance at 30 (thirty) days past the date that Dr. Campbell's office receives benefits paid by my insurance company.

-I understand that finance charges will continue to be added each month until the balance is paid in full.

-I understand, if it is necessary to commence collection proceedings, the responsible party for this account shall pay all collection fees.

-I understand, if alternate payment arrangements are made with Dr. Campbell's office, they will be documented. If I do not comply with the arrangements made, the above listed actions will be taken.

-I authorize Dr. Campbell to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependant during the period of such dental care to third party payors and/or health practitioners.

-I authorize and request payment of the dental benefits otherwise payable to be directly to Jack P. Campbell, DMD.

-I agree to be responsible for the payment of all services rendered on my behalf or on the behalf of my dependants.

-I certify that I have read and understand the above information.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE
(OR LEGAL GUARDIAN): _____ **DATE:** _____