

Cache Valley Smile Design

Dr. Matthew Cheney, DMD
167 East 200 North Suite 3 Logan, Utah 84321

- I understand that interest will be charged at the rate of 1.5% per month (per annum) on the unpaid balance on all accounts. The interest shall be accrued both before and after a judgment, if any, is entered.
- In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, unless other financial arrangements are made. I further agree that the reasonable values of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I agree to pay 100% of all reasonable costs and attorney fees if suit be instituted hereunder to collect monies owed by me, including interest charges, processing fees, collection costs that may be assessed by any collection agency related to pursue this matter.
- I understand that a fee of \$45.00 per appointed hour will be charged for missed appointments and cancellations with less than 24 hours notice.
- **I understand that payment must be made at the time services are rendered unless previous arrangements have been made. I understand that the Cache Valley Smile Design will file my insurance as a courtesy. It is my responsibility to know my insurance benefits; the contract is between me and my insurance company. All transactions on my account are my responsibility.**
- I grant my permission to you or your assignee to telephone me at home or at my work place to discuss matters relating to this form.
- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services.**

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined there in.

Signature of Patient, Parent, Guardian

Date

Relationship to Patient