

University Periodontal Associates

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FINANCIAL POLICY

I UNDERSTAND AND AGREE that all fees are the responsibility of the patient and/or responsible party, due and payable within 90 days from the date of service, irrespective and regardless of any insurance claims or other anticipated benefits. Account balances older than 90 days will be subject to a late fee of \$20 per month, and further subject to collection fees which would accrue should it become necessary to enlist an outside agency.

Patient/Responsible Party

Date

I HEREBY AUTHORIZE PAYMENT directly to University Periodontal Associates of benefits to me for services provided by Dr. David Dennison or his representatives. I understand that I am financially responsible for the entire cost of services provided regardless of insurance coverage. I hereby authorize the release of any information acquired in the course of my treatment as may be necessary to process my insurance claim.

Patient/Responsible Party

Date