INSTRUCTIONS: **(1) Please Print (2) Fill out completely, (3) Read carefully, including reverse, and sign.**

Patient's Name _____ Date of Birth _____
Last First Initial

Single ☐ Married ☐ Divorced ☐ Minor ☐ How do you wish to be addressed? _____

E-mail Address _____ Home Phone _____ Cell Phone _____

Home Address _____
Street Apt. City State Zip

Patient/Parent Employed by: _____
Firm Address

Position _____ How long? _____ Business Phone _____

Patient/Parent SS# _____ DL. Number _____

Spouse/ Other Parent Employed by _____
Firm Address

Position _____ How Long? _____ Business Phone _____

Spouse/Other SS# _____ DL. Number _____

Whom may we thank for your referral to our practice? _____

Other family members we will be seeing in our practice:

Name _____ Relation _____ Birthday _____

Name _____ Relation _____ Birthday _____

Name _____ Relation _____ Birthday _____

Next of Kin not living with you to contact in case of emergency: Name: _____

Address _____ Phone: _____

DENTAL INSURANCE 1ST COVERAGE

Employee _____ SS# _____ Date of Birth _____

Employer _____ Address _____

Insurance Co. _____ Policy# _____ Union or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee _____ SS# _____ Date of Birth _____

Employer _____ Address _____

Insurance Co. _____ Policy# _____ Union or Group _____

YOU WILL BE CHARGED $75.00 PER HOUR FOR BROKEN APPOINTMENTS WITHOUT 24 HOURS NOTICE!

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my family's dental care for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Dr. Henry, unless I specifically request otherwise at time of service.
- I attest to the accuracy of the information on this page.

I HAVE READ THE ATTACHED TRUTH IN LENDING STATMENT, AND I HAVE RECEIVED A FULLY COMPLETED COPY OF THIS FINANCIAL AGREEMENT.

Signature _____ **Date** _____

PATIENT REGISTRATION

FINANCIAL AGREEMENT

1. I, the undersigned, agree to pay the amount charged by the doctor for all professional services rendered to myself, my family, or to any other patient indicated on the reverse.

2. I, the undersign, agree that regardless of my insurance coverage, agreement to receive treatment represents a contract between myself and the doctor, with the insurance company remaining as a third party. **RESPONSIBILITY FOR PAYMENT REST ULTIMATELY WITH THE PATIENT, REGARDLESS OF INSURANCE COVERAGE!**

3. I understand that in the event of non payment of bills for dental services, this office routinely seeks remedy through a collection agency. Being turned over for collections will adversely affect my credit history and will jeopardize my ability to obtain credit from other sources.

4. Further remedies for non payment of professional bills include judgments in courts with ensuing liens on property and garnishment of wages. I, the undersign, agree to the reasonable of such remedies, and agree to bear the burden of such collection costs including, but not limited to, collection agency fees, lawyer fees, court costs, and filing fees.

5. 28 days after statement closing date, always a minimum of 28 days from date of service. I agree to pay the doctor the following charges **IN ADDITION** to the fees for professional services: **A FINANCE CHARGE of 1 ¾ % per month (21% per annum.)** The finance charge and rebilling fees will be applied to my adjusted balance (previous balance after deducting current payment and/or credits appearing on my statements.)

6. I can avoid incurring FINANCE AND REBILLING charges by paying my account IN FULL upon receipt of statement provided that payment is actually received by doctor before the next billing date. This allows for a minimum of 28 days from date of service to my account without incurring FINANCE OR REBILLING FEES. **I UNDERSTAND THAT IT IS TO MY ADVANTAGE TO PAY MY BILL AS QUICKLY AS POSSIBLE!**

IN CASE OF BILLING ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

I. If you want to preserve your rights under the Act., here is what to do if you think your bill is wrong you need more information about an item on your bill:

A. Do not write on the bill. On a separate sheet of paper write the following (You may also telephone your inquiry **but doing so will not preserve your rights under this law.**)

1. Your name and account number.
2. A description of the error and an explanation (to the extent you can explain) why you believe it is an error. If you only need more information explain the item you are not sure about and if you wish ask for evidence of the charge. Do not send in your copy of any document relating to such charges unless you have a duplicate copy for your records.
3. The dollar amount of the suspected error.
4. Any other information (such as your address) which you think will help us identify you or the reason for your complaint or inquiry.

B. Send your billing error notice to**: Kim Henry, D.M.D. 1515 Morrow Road, Morrow, Georgia 30260**

II. We must acknowledge all letters, pointing out possible errors within 30 days of receipt unless we are able to correct your bill during that 30 day period. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill was correct. Once we have explained the bill we have no further obligation to you even though you still believe there is an error except as provided in Paragraph V below.

III. After we have been notified, neither we nor an attorney nor a collection agency may send you Collection letters or take other collection action with respect to the amount in dispute but periodic statements may be sent to you and the disputed amount can be included in determining your present account balance, You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. **However, you remain obligated to pay that portion of your bill which is not in dispute.**

IV. If it is determined that we have made a mistake on your bill, you will not have to pay any **FINANCE CHARGES** on any disputed amount. If it turns out that we have not made an error, you may have to pay on the amount in dispute and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct we must send you a written notification of what you owe; and if it is determined that we did make a mistake in billing the disputed amount, you must be given the time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged on you.

V. If the explanation given by us does not satisfy you and you notify us **in writing** within **ten days** after you receive its explanation that you still refuse to pay the disputed amount we may report you to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that you think you do not owe the money and we must let you know to whom such reports were made. Once the matter has been settled between you and us, the resolution of the matter must be reported by us to all parties to whom it has originally reported you as delinquent.

VI. If we do not follow these rules, we are not allowed to collect the first $50.00 of the disputed amount and finance charges, even if the bill turns out to be correct.

"The federal Equal Credit Opportunity Act prohibits from discriminating against applicants on the basis of sex or marital status. The Federal agency which administers compliance with this law concerning this doctor is the Federal Trade Commission, 55 East Monroe Street, Chicago, Illinois 60603".