The Smile Zone
576 Sand Creek Road
Albany, New York

POLICY OF UNDERSTANDING
FINANCIAL AGREEMENT

As a condition of my treatment by the Smile Zone I understand that I am financially responsible for payment of all dental services.

I realize that failure to keep this account current may result in me being unable to receive additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable fees incurred in attempting to collect on this amount or any future account balance.

I understand a fee of $50 is charged if I cancel an appointment more than 2 times without 48 hours' notice. For larger, more comprehensive treatment plans, if I break an appointment, a $100.00 deposit is required to secure my next appointment.

I acknowledge the Smile Zone charges $35.00 for all returned checks.

Insurance is a contract between you and the insurance company. The Smile Zone will work with your carrier to maximize your benefits; however, you are responsible for the timely payment of your account. Deductibles, Co-payments and Co-insurances are due to the time services, unless otherwise noted.

Consent for Treatment

I, _____, consent to and agree to radiographic and clinical examinations along with any diagnosis of treatment.

Signature of Patient, parent of guardian: _____
Relationship to Patient:_____

Signature of guarantor of payment/responsible party:_____
Relationship to Patient:_____

AUTHORIZATION FOR SIGNATURE ON FILE (Patients with insurance)

I, _____hereby authorize the Smile Zone to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my (circle one): Employer/spouse/retirement/parent with (name of insurance company): _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of the Smile Zone. This "Signature of File" will be valid as long as this insurance is in effect and I am an active patient of record. A photocopy of this document may act as an original.