DR. GARY S. BARKER
General, Reconstructive & Cosmetic Dentistry

8131-J Ritchie Highway
Pasadena, MD 21122
410-64-SMILE (76453)
BarkerSmiles@gmail.com

Authorization and Financial Agreement

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payers and health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that I am subject to a $35 per half hour of appointment time when not showing for or canceling an appointment with less than 36 hours' notice.

I understand that payment is due at time of service unless other written arrangements have been made. I understand IV Sedation appointments require advance payment in full at the time of scheduling the appointment. Advance payment reserves the time and day for the IV Sedation appointment. If the appointment is cancelled for any reason with at least 36 hours' notice, full payment will be refunded. If the IV sedation appointment is cancelled for any reason with less than 36' hours' notice, a $35 per half hour of appointment time will be subtracted from the refunded amount.

If for some reason the insurance company has not paid their portion within 45 days from the start of treatment, I am responsible for payment at that time.

All bills are due upon receipt. In the event payments are not received within 30 days, I understand that a 1.5 % per month carrying charge (18%APR) will be added to my account. There is a billing fee of $8 for bills sent after the first one. If a courtesy reduction is given towards services rendered, that discount is contingent upon payment made within 30 days of service unless other written arrangements have been made. If this account is turned over for collection, whether a suit is filed in this matter or not, I agree to pay all costs of collection including but not limited to attorney fees of 33 1/3% of the outstanding monies due and owing or on any judgment amount, all court costs incurred and process service costs.

I understand all overpayments over $25 will be automatically refunded to me once all outstanding claims have been processes by my insurance (if applicable). Overpayments under $25 will remain credited to my account for future use unless I request a reimbursement.

_____
Patient Name (please print)

_____ _____
Patient or Guardian Signature Date