OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment is rendered. All emergency dental services or any dental services performed without previous financial arrangements must be paid in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extender for a period of three months from the date of the patient examination. I further understand that any appointments I fail to keep and/or cancel without 24 hours notice will be charged to my account.

In consideration for the professional services rendered to me, or, at my request, for my minor child or ward, by Dr. Baldwin, Dr. Petersen, or their staff, I agree to pay the reasonable value of those services to Dr. Baldwin, Dr. Petersen, or their assignee, at the time the services are rendered, or within five (5) days of billing, if credit shall be extended. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing forty (40%) percent of this principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or the collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave a message concerning appointments and/or results on my answering machine or with a family member.

The agreement supersedes all prior agreements signed including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize Dr. Baldwin, Dr. Petersen, or their designees, to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information, and that copies may be submitted for the originals.

I acknowledge that I have reviewed, and received at my request, a summary of this office's Privacy Policies. A copy of the full Privacy Statement is available upon request. I agree to disclose to Dr. Baldwin or Dr. Petersen the names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all the questions on these forms accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

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Signature of Patient, Parent of Guardian	Date	Relationship to Patient