THOMAS R. FELCHER, D.D.S.

Stockbridge Dental Care, P.C.

Please be advised that the treatment plan presented to you today is given from an oral evaluation and any necessary x-rays taken. Should treatment vary due to unforeseen circumstances, I understand that this treatment plan shall be subject to adjustment along with the fees associated with each procedure.

I understand that payment is due at the time of service. If an insurance claim is filed, the estimated portion from my insurance company is an estimate and in no way guarantees their amount of payment. **Any difference between the estimate given and the insurance company's actual payment will be my responsibility**. I understand that Stockbridge Dental Care, P.C. is filing my insurance as a courtesy and accepts no liability concerning my coverage. That Stockbridge Dental Care will not enter into a dispute with my insurance company and that it is my total responsibility and obligation to know what my insurance benefits are.

I am aware that Dr. Felcher does **not do amalgam (mercury) fillings** and I have been informed that my insurance company may or may not cover composite (tooth colored) fillings.

Stockbridge Dental Care, P.C. agrees to allow **60 days** for my insurance company to remit payment. After 60 days, regardless of insurance coverage, **I will assume full responsibility and will remit payment in full on my account.** Any delinquency over 60 days will accrue 1.500% interest monthly to my balance. Accounts referred to our attorney shall incur 15% attorney's fees. All delinquent accounts over 90 days will be subject to reporting to Equifax Credit.

I agree to assign benefits payable by my insurance, under the terms of my employment, to Stockbridge Dental Care, P.C.

I understand that should I need to reschedule an appointment, I will do so during normal business hours, 24 hours prior to my appointment, otherwise **I am subject to a minimum $50.00 broken appointment fee**. Our fee for a check returned as non-sufficient is $25.00.

Signed ______________________________ Responsible Party ___________Date