Unique Dental Care, PLLC
"Let Us Brighten Your Smile"

FINANCIAL AND INSURANCE AGREEMENT

I hereby accept full financial responsibility for the prompt payment of all medical and/or dental services rendered to _________________________________, by Unique Dental Care, PLLC, (Franklin Daniel, D.D.S.). I agree to pay promptly
(Name of Patient)
in full any additional fee, cost, and/or expenses, including, but not limited to, investigative costs, attorney's fees, court costs, filing fees, interests, penalties and all other cost and expenses actually incurred by or on behalf of Unique Dental Care, PLLC, (Dr. Daniel) in the event service of an attorney and/or collection agency are utilized for the purpose of collecting any delinquent balance due on this account. I also understand that, as a courtesy to me, Unique Dental Care, PLLC will assist me in processing any insurance claims. However, in the event forty (40) days have passed from the date of submission of my claim to my insurance carrier and the balance remain unpaid, I agree to immediately pay the balance due on this account to Unique Dental Care, PLLC. I agree to pay interest at the rate of one and one half (1 ½%) percent per month on this account if it remains unpaid for forty (40) days from the date the insurance was submitted to my insurance carrier. If they do not receive or lose this claim, it will be the responsibility of the patient to process the claim. I understand and accept that procedures and/or services **not covered by my insurance carrier will not be billed to them**, and by signing this, I also **agree I am fully responsible for those charges**.

By signing this agreement, I understand that lumping, bundling, and/or changing of CDT-4/CPT diagnostic codes is a method used by insurance carriers to reduce reimbursement. This practice of changing the diagnosis is not accepted by the American Dental Association or Unique Dental Care, PLLC and will not be allowed to reduce our financial obligations for services.

By signing this statement, I agree to the assignment of benefits to Dr. Franklin Daniel for any services performed in the office or in a hospital.

There will be a $40.00 Service Fee added for all NSF checks.

I agree to pay a 25% collection fee if my account is turned over to a collection agency.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Name: _______________________________________ Date: _______________________

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(Please Print)

Co-Signer Agreement

(You must have a co-signer if you are covered under your parent/guardian's insurance plan). As a co-signer for, _____________________________, I personally guarantee payment of all medical and dental expenses incurred by this patient at Unique Dental Care, PLLC for products and services rendered by, Dr. Franklin Daniel. I personally guarantee payment in full of any additional collection fees, costs and expenses including, but not limited to, attorney's fees, court costs, filing fees, investigative expenses, penalties and all other fees Unique Dental Care, PLLC may incur in the event that the services of any attorney and/or collection agency are utilized for the purpose of collecting this account.

Name: ____ Date: _________________________
(Signature)