14420 Sommerville Ct. Midlothian, VA 23113 Phone: (804) 897-7900 email: dentist@dentistrichmond.com

Today's date: ____/____/____ Whom may we thank for referring you? _____

PERSONAL INFORMATION

MR MS
Name: MRS DR _____
First M. Last

I prefer to be called: _____ Single Married Divorced Widowed Male Female

Birth-date: _____/_____/_____ **SSN:**_____-_____-_____
Required ***Required***

Home Address: _____
Street City State Zip

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Email:_____

Employer: _____ Address: _____

Work Phone: _____ Ext._____

Spouse Name: _____ Birth-date: ____/____/____ **SSN:**_____-_____-_____

Employer: _____ Work #: _____ Ext.: _____

In the event of an emergency, is there someone whom we should contact other than your spouse?

Name: _____ Relation: _____ Home #: _____ Other #: _____

DENTAL INSURANCE

Employer: _____ Phone No. (____)____-_____

Insurance Company:_____ Group No._____

Name of Policyholder:_____ SSN: _____-_____-_____

Policyholder Date of Birth: ____/ ____/ ____ Relationship to patient: _____

Insurance Phone Number: (____)____-_____

Ins. Co. Address:

_____
Street or PO Box # City State Zip

As a courtesy we will estimate your portion based on your provider's anticipated reimbursement to us.

PATIENT FINANCIAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY, INTITIAL EACH AND SIGN BELOW

This agreement is between the undersigned and Midlothian Family Dentistry (the "Contract"). Any term of the Contract that may be found unlawful shall be stricken and the remainder of the Contract shall remain fully enforceable and in effect.

____ I understand all patient portions including deductibles and co-pays are due and payable at the time services are rendered.

____ I authorize payment directly to Midlothian Family Dentistry for the benefit otherwise payable to me under the terms of any insurance. I understand any insurance payments will be credited to the account. I also understand that I am financially responsible for any portion my insurance may not cover for the total treatment fee, or if for any reason my insurance provider does not honor their commitment to either myself or MFD.

____ I understand that I am to remit within 60 days in order to keep my account current, any insurance reimbursements paid directly to me by my insurance provider for services rendered by MFD.

____ If all charges are not paid in full within sixty (**60**) days from the date of service I agree to pay a one-time service charge of **$5.00.** A payment is late if it is not received within sixty (60) days of the date the service was performed (the "Late Payment"). For charges not paid in full within 90 days, interest on the unpaid balance of 1.8% per month, twenty-one (21%) per annum, (the "Default Interest Rate") accrues. A sum of money only constitutes a "payment" when that sum is successfully deposited by Midlothian Family Dentistry, clears the account, and is not involuntarily transferred away. I agree that Midlothian Family Dentistry has the option but not the obligation to find me in default under this Contract, without notice, as a result of a Late Payment or any other violation of the terms of the Contract (the "Default"). Midlothian Family Dentistry's acceptance of a Late Payment does not revoke a Default under the Contract absent written consent from Midlothian Family Dentistry.

____ If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third percentage (**33 1/3%**) of total balance owed. Late Payments shall be applied first to principle, second to interest accrued and third to any and all attorney fees including court costs, if applicable. For accounts in collections, payments must be made to attorneys. MFD is not authorized to accept payments for accounts turned over to collections.

____ In the event the bank returns any check given in payment on this account unpaid for any reason, a $35.00 charge will be added to the account balance each time such a check is returned.

____ **I understand that I will be charged a minimum fee of $50 per one-half (1/2) hour for all missed or cancelled appointments unless forty-eight hours (2 business days) notice is given.**

Cancellations are not accepted via email, text or voicemail.

NAME: _____ **Relationship to Patient: _____**

SIGNATURE: _____ **DATE: ____/____/____**

Midlothian Family Dentistry Authorization: _____