SYLVAN HEIGHTS DENTAL
Jeremiah Leary DMD
5440 SW Westgate Dr #165
Portland, OR 97221
Phone: 503-297-2471

- I understand that insurance is billed as a courtesy to patients; that insurance benefits are very difficult to calculate, except in advance processing of an actual claim, and that Dr. Leary, DMD is not bound by rough insurance estimates. All estimated patient portions are due at the time of service unless prior arrangements have been made.

- I understand that my insurance contract is between my insurance company and myself, and may be unique to my situation, including but not limited to; its own allowable fee schedule, deductibles, waiting periods, excluded services, frequency limits and alternate benefits applied towards treatment rendered.

- I understand I am fully responsible for all charges for dental services and agree to pay in full any balance not paid by my insurance company within 30-days of notice of each service rendered.

- I understand my insurance claims are my responsibility, and agree to follow all pending claims to insure they are processed in a timely manner. Traditionally claims are responded to within 30 days.

- I understand Dr. Leary, DMD does not diagnose dental treatment to "specific dental plan descriptions" and legally cannot change treatment rendered through billing of claims to acquire additional benefits.

- I agree to pay a service fee computed at the rate of 18% per annum on any outstanding balance over 60-days from date of service. In the event of a returned NSF check, I agree to pay a $25.00 fee with 15-days of notice.

- I agree to give Dr. Leary's office 48-hours' notice for any appointment that I need to cancel/reschedule. This does not include weekend notifications for a Monday appointment, which would need notice during the prior week. If I fail to allow this 48-hour notice, I agree to pay a missed appointment fee of $75.00 per hour appointment within 30 days if applied.

- I understand in the event my account is assigned to a collection agency for legal action, there will be an "additional collection fee of $400.00" added to my account balance, and I will assume all legal costs and reasonable attorney fees as may be required to effect collection.

- I understand and agree fully to the above disclosure. I understand my responsibility to ask questions and express any concerns regarding dental treatment diagnosed/treatment options, and any financial arrangements prior to treatment being performed.

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Signature Date