Mathew D. Schweppe, D.D.S.
Pediatric Dentistry

Financial Agreement

- If the patient does not have dental insurance, payment in full is expected on the day of service
- If the patient has dental insurance, the responsible party will need to pay the deductible and patient's estimated portion on the day of service. The insurance will be billed as a courtesy, however **please be aware that if the insurance does not pay within 60 days, payment in full will be expected** from the responsible party
- Upon examination Dr Schweppe will prepare a treatment plan. The **treatment plan is only an estimate** of the dental care required and should not be construed as a statement of actual charges
- If the patient is unable to attend a scheduled appointment, the responsible party will need to call 24 hours in advance to reschedule or cancel. Otherwise a **$50 missed appointment fee** will be charged to the responsible party
- When scheduling dental surgery a **$100 NON-REFUNDABLE deposit** is required on all patients and is due the day surgery is scheduled. If you do not show up for surgery or do not comply with the guidelines on the consent form, you will forfeit your deposit. All patient portions on treatment estimates must be paid on or before the surgery date. *****Please take note***** you will receive a separate bill from the Hospital or Outpatient Facility and the Anesthesiologist
- I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a 40% collection fee if my account is assigned to a collections agency
- **Permission to contact via cellular telephone:** We want to stay in touch with you regarding your account. Since most people only have cell phones we will need your permission to call your cell phone. Signing this agreement will allow us to do that. Please let us know if you have questions or would like to discuss this. In order for us, or for any other person or entity who provides good or services to you in connection with this agreement, to contact you regarding servicing your account(s), including all past and current accounts, or to collect any amounts you may owe for any past or current account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other or entity that provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone number or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection
- Surgical Center and Hospital Disclosure: Dr Schweppe may have a financial interest in the Hospital or Surgical Center used for the treatment of your child
- Referral Disclosure: Dentists to whom this Facility refers patients may financially or otherwise compensate this Facility. None of the compensation is charged to the Patient. This Facility is a Member of, and thus financially interested in, Dental Cooperative, a network of quality dentists. We may refer the Patient to the Dental Cooperative or to another member of the Dental Cooperative

I have read the above Policies and agree to abide by them.

_____
Patient Name

_____ _____
Parent/Guardian Signature Date

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South Ogden, UT 84403
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