Dr. David Willis, DMD

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Financial Agreement and Policies

The following are the terms and conditions hereinafter ("Agreement") governing all amounts owing to Willis Dental, David G. Willis, DMD, LLC an Oregon Limited Liability Company, as creditor, from the Patient/Debtor and/or Responsible Party signing below. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor and/or Responsible Party. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to David G. Willis DMD, Willis Dental. By signing below, you are agreeing to pay for all services that are received as required under this Agreement. By signing below you are acknowledging that all of the information provided to us is complete and accurate

All charges you incur are your responsibility regardless of your insurance coverage.

***************Insurance coverage*** is a valuable asset in restoring and maintaining good health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our office is not a part of that contract and the final responsibility of payment is yours. As a courtesy to you, we will process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

***************Your portion of the payment*** **is due at the time of services rendered.** We accept cash, money orders, and personal checks, Visa, Master Card, Discover, American Express and Care Credit. There is a fee for returned checks by the bank. The current fee is $30.00. One and one-half percent (1.5%) per month interest (18% annually) will be charged on accounts 90 days from the treatment date.
NOTE: If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and collections costs.

***************All missed and cancelled appointments*** **with less that a 24-hour notice**, the 1st time will be allowed to reschedule. A 2nd missed appointment the patient will receive a warning. A 3rd missed or cancelled appointment with less than 24 hours, the patient, guarantor on account will be required to pay a down payment of $75, paid by credit card at the time of rescheduling of their dental appointment. This is non-negotiable and will only be refunded with a $0 account balance after treatment completed or insurance benefits have been received. Willis Dental reserves the right to dismiss a patient and family members on the same account who do not comply to these guidelines.

I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for the payment of my account.

Signature_____Date:_____