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Truth-in-Lending Statement

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements, in writing, must be paid for in cash at the time of service.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making insurance collections, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon. The patient will be responsible for all costs of collecting any past-due accounts, including reasonable attorney's fees.

I understand that fee estimates for dental care are valid only for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless I object, in writing, within the time payment is due. I further agree that if this office waives any breach of any condition hereunder, this shall not institute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I hereby consent to such procedures that may be prescribed. I grant my permission to you, or your assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party: _____

Relationship to patient: _____ Date: _____