Please read and initial each line.

________ I authorize my insurance company to pay Dr. Lucy B. Sloan all insurance benefits. I authorize the use of this signature on all insurance submissions.

________ I authorize Dr. Lucy B. Sloan to release any dental/medical information necessary to secure the payment of benefits.

________ I understand that even though I may have some type of insurance coverage, I am fully responsible for payment of services rendered by Dr. Lucy B. Sloan. It is my responsibility to contact my insurance company to solve any payment discrrepancies. I understand that an authorization from my insurance company is **not a guarantee of payment**. Monitoring my insurance for maximum benefits is my responsibility.

________ **All estimated co-payments must be paid at the time of service** . If the deductible has not been met, this must be satisfied as well. I understand that having dual coverage does not guarantee 100% payment by the 2 insurance companies as some companies have a non duplicate of benefits clause.

________ I understand payment is due for all services rendered unless prior financial arrangements have been made.

________ I understand that there will be a $50 charge for a canceled or missed appointment if a 24 hour notice is not given.

________ I understand that the parent who brings a child in for treatment, is responsible for that child's account balance. Without written consent authorization, no patient under the age of 18 will be treated without a responsible adult present.

________ I understand that this office charges a service fee in the amount of $30 for a returned check.

________ I understand Dr. Lucy B. Sloan has a notice of Privacy Practice Policy posted in the office at all times. If requested, I may also recieve a copy of the policy.

______________________________ ________________________

Patient (parent or guardian of minor) Date