Pay Agreement and Insurance Information

Patient Name:_____ DOB:_____

- Person Responsible for Account:_____ DOB:_____
  Address:_____ Home #_____ Cell#_____
  Social Security #_____ Drivers License #_____
  Employer:_____ Work #_____
- Spouse of Responsible Party:_____ DOB:_____
  Address: _____ Home #_____ Cell #_____
  Social Security #_____ Drivers License #_____
  Employer:_____ Work #_____

Are you covered by dental insurance? Yes____ No____

- Policy holder:_____ DOB:_____ ID #_____
  Social Security #_____ Driver's License #_____
  Employer:_____ Business #_____
  Insurance Company Name and Contact Info._____
  _____ Group #_____

- Secondary Ins. Policy Holder: _____ DOB:_____ID#_____
  Social Security #_____ Drivers License #_____
  Insurance Company Name and Contact Info._____
  _____ Group #_____

Agreement for Extension of Credit

In accordance with the Federal Truth-in Lending Act which requires all doctors to give their patients complete information in connection with extension of credit; please be advised of the following credit policies that apply to this office.

1. Payment is requested at the time of treatment, unless specific arrangements have been made.
2. Payment on accounts billed is expected within thirty (30) days.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to know if Dr. McArthur is on your dental plan, to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. We will be happy to assist you whenever possible, but you are responsible for your account.

I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled,private insurance, or other health plans to Dr. Nathan J. McArthur, and authorize those entities to release all information necessary to secure payment. I also authorize those entities to release all information necessary to secure payment. I also authorize disclosure to my other physicians concerning my present condition or injury.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

Signed: (Patient or Legal Guardian)_____ Date:_____