AUTHORIZATION & ACKNOWLEDGEMENT

I authorize Greencastle 20/20 Dental and staff to treat me and the person(s) for whom I have financial responsibility.

I understand I am Financially responsible for all services rendered and for charges not timely paid by my insurance company and understand that I am financially responsible for any balance not covered by the insurance company.

I understand that if my account at any time becomes more than sixty days delinquent an interest charge of 18% will be added monthly to my accounts remaining balance. The minimum finance charge is .50 cents and the minimum balance is $10.00. If your account becomes 90 days delinquent it will be subject to being placed with a collection agency.

The Responsible party is liable for all expenses incurred in collection procedures including collection fees of 40%, attorney fees, court costs, as well as the remaining balance on my account.

A service charge of $25 will be added for any check returned for NSF.

I authorize the insurance company to pay benefits directly to Greencastle 20/20 Dental, LLC.

I authorize the release of any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of this authorization shall be as valid as the original.

Guarantor's Signature _____

Print Guarantor's Name _____

PRINT Patient(s) names / relationship to patient(s)

_____

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_____

_____

_____

Date _____