

M. Lewis Grubbs, D.M.D.

*1771 Lelia Drive
Jackson, MS 39216*

In an effort to keep the cost of dental services down and help eliminate confusion about your account, Dr. Lewis Grubbs, D.M.D. would like to reiterate his financial policies. PLEASE READ AND SIGN.

1. I, the undersigned consent to an examination (physical, photographic and/or radiographic x-ray) of me or my dependent by Dr. Lewis Grubbs, for the purposes of diagnosis of any afflictions for which I may or may not have sought treatment. I understand that treatment recommendations may be made and discussed and it is my right and duty to decide whether or not to accept and follow those recommendations or alternative recommendations that may be made. I understand that failure to follow prescribed course of treatment may be against my best interest and I accept full responsibility for my decision and actions.
2. I understand that this is a fee-for-service practice and unless there is a PRIOR AGREEMENT, ALL FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. We accept cash, check, most major credit cards and CareCredit financing. I understand that a service fee of \$5.00 may be assessed on any past due accounts and an interest charge of 1.5% per month or 18% per year may be assessed on any accounts greater than 90 days past due. THIS WILL APPLY TO ALL ACCOUNT BALANCES INCLUDING THOSE THAT EXIST WHEN INSURANCE COMPANIES DELAY MAKING THEIR PAYMENTS. I agree to pay any reasonable costs incurred by Dr. Lewis Grubbs or his designate in attempting to collect past due accounts as are due from me, including legal fees and court costs. I understand that there will be a \$20.00 service charge for any returned checks.
3. CONCERNING DENTAL INSURANCE: Dental services are recommended and provided for you, the patient. The patient is responsible for the ENTIRE FEE for services they accept. Dental insurance is a benefit that your employer provides you to assist in paying for dental cost. Filing your dental insurance is a benefit our office provides you, not a responsibility of our office. Dental insurance does not release you from your financial responsibility for the dental treatment that you have accepted. YOU ARE ULTIMATELY RESPONSIBLE FOR ANY AND ALL FEES DUE. For any claims to be filed we must have accurate up to date insurance information and we will provide all necessary information regarding the dental treatment. If your claim is returned to us because of incorrect information that you have provided then there may be a \$5.00 service charge to cover the cost of refileing. The insurance company works for the patient not the dentist, when there is a dispute on a claim it is the patients responsibility to settle the difference with the insurance company. We will provide you with any information you may need in your discussion with them. It has been our experience that insurance companies will respond quicker to the patient's request than to ours.

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4. I warrant that any and all answers that I may give relating to identification, insurance information, medical history and treatment follow-up shall be truthful to the best of my knowledge.

We thank you for your cooperation on implementing these policies.

Patient/Guardian Signature _____ Date _____