PETER B. PRYOR Jr.
DMD

Financial Policy

We are pleased that you have selected us as your dental provider. For your knowledge, our Financial Policy is outlined below.

Promise to pay: Amounts for dental care services provided to you or your family members may be charged to your Account unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company, We will assist you with an insurance claim; however, insurance is a contract between the policyholder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee: We may charge your Account fees for a missed appointment or fees for an appointment cancelled without advance notice of at least 24 hours.

Late Payment Fee: If we do not receive payment in full, of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of 2.00% of your unpaid Balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

Returned Payment Fee: If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $25.00 and may be adjusted.

Collection Costs: If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extend not prohibited by applicable law.

No Waiver by Us: We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports: We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we," "us," "our," and "Provider" mean the service provider mentioned above. "Services" means any services provided by us, "You," "your," and "Account holder," mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for your (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

_____ /_____/_____

Account Holder's Name Printed Name Date

No, I am not interested in establishing an account and therefore understand that full payment for dental care services, subject to limitations imposed by my insurance company, if any, is due at the time of appointment.

_____/_____/_____

Signature Printed Name Date