Thank You For Choosing United Smiles
PAYMENT FINANCIAL AGREEMENT

United Smiles requires all patients to make financial arrangements with us before we provide treatment. In order to receive treatment from us, you are making the following representations to us, which you affirm that you have read, understand and agree to:

1. I understand that full payment Is due at the time of service including emergency visits for myself or any of my dependents or at the initiation of service under a treatment plan that I or any of my dependents have requested. My payment options are cash, check and major credit cards. Further, if I qualify based solely on my credit history and income, a financing program may be available through a financial institution that United Smiles has a relationship with. (**I understand that United Smiles has no obligation to provide or procure financing for services they render on behalf of myself or my dependents.**)

2. In the event that United Smiles is able to verify that I or any of my dependents have insurance coverage from information that I provide, I understand that I will still be required to pay in full the portion of United Smiles billing for any procedure or treatment plan requested for myself or my dependents that United Smiles estimates will not be covered by my insurance prior to such treatment being performed by United Smiles. I understand that this estimate of insurance by United Smiles may differ from the payments ultimateIy made by my insurance carrier and that I am responsible for any amounts not paid by my insurance for any reason.

3. With respect to any dental insurance that I may have, I understand that my insurance benefits are derived from a contract between either myself or my employer and the insurance carrier. I also understand that the extent of my insurance coverage depends upon the quality of the plan that I or my employer has purchased.

4. I realize that it is solely my responsibility and not the responsibility of United Smiles, to confirm which treatment procedures are covered by my insurance, the extent of this coverage including any applicable exclusions or deductibles, annual or lifetime maximums in my policy and any disparity between the fees charged by United Smiles for a procedure for which I am responsible for, and the amount of the benefit payment allowed by my insurance carrier's usual customary fee schedule.

5. I understand that all insurance claims from treatment that I receive a t United Smiles are being filed by United Smiles with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand that United Smiles will submit a claim with my insurance carrier up to 2 times per appointment and that any further insurance appeals are solely my responsibility. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance for any reason, including but not limited to, my insurance company denying coverage for a procedure, policy deductibles, policy maximum annual or lifetime benefits being exceeded, my insurance carrier pays an amount for a procedure based on its usual and customary benefit schedule which is less than the fees charged by United Smiles for such procedure and United Smiles not receiving a payment within 60 days of the procedure to be performed even If I am appealing the denial of insurance benefits by my carrier.

6. I understand that if I opt to discontinue treatment for a procedure I previously requested United Smiles to perform including but not limited to, Partials, Dentures, Crowns, Bridgework and Surgical preparatory work, I will be responsible for paying all lab related costs for materials and services that were provided for my benefit prior to decision to discontinue such treatment and that all such costs will be deducted from any refund that I may be entitled to as a result of any pre- payments for the requested services.

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I understand that any and all account balances over 30 days old will Incur a monthly interest charge at the maximum late rate allowed.**

I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to United Smiles, for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged a service charge. This charge is currently $25.00 and is subject to change without notice.

I understand, that I have the right to dispute charges on my account and agree in good faith to resolve such disputed charges with United Smiles. To the extent that I am unable to resolve such matters directly with United Smiles, I agree to pursue resolution through an informal mediation process with a mutually agreeable independent third party rather than through litigation.

I understand that if my account is not paid on a timely basis, United Smiles may report such untimely payments to credit rating bureaus, refer my account to a collection agency and take legal action against me in order to receive full payment for services performed on myself or any of my dependents. I agree to pay all related reasonable attorney's fees, collection and/or court costs, and a monthly interest charge on my outstanding account balance at the maximum rate permitted by law.

I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays and treatment information is currently $15.00 and subject to change without notice.

I understand that United Smiles reserves the right to charge a fee for any appointment that I do not keep, currently $50 and subject to change without notice. After two broken or missed appointments, the dentist retains the right to discontinue elective treatment and to dismiss me from the practice.

I have thoroughly read, understand and agree to the above Patient Financial Agreement with United Smiles and Its Affiliates.

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Signature of Patient Date

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Signature of Guardian Responsible for Patient Date

**Interest charges will accrue on balances that have not been paid on the 30th day after the billing date. Late payment fees and returned check fees, if any, are not included in the daily/monthly balance. The interest rate that United Smiles shall be 18% per month or the highest rate permitted under the applicable law of Virginia. Your payment of any outstanding balance may be allocated in a manner which United Smiles determines and is legally allowed, and may be changed from time to time. United Smiles reserves the right to apply payments to balances with lower interest rates.