MCKINLEY & ALEXANDER DENTISTRY
224-I S. NEW HOPE ROAD
GASTONIA, NC 28054

OFFICE POLICY

Following are the office policies for the practice of Susan M. McKinley, DDS. PA. & Paul J. Alexander DDS
By executing this agreement, you are agreeing to pay for all services that are received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments and credits applied to your account during the month.

INSURANCE: Insurance is a contract between you an your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what you insurance company may pay, it is the insurance company that makes the final determination of eligibility. You agree to pay any portion of the charges not covered by insurance.

FINANCE CHARGE: A finance charge will be imposed on each item if your account which has not been paid within thirty days of the time the item was added to you account. THE FINANCE CHARGE will be computed at the rate of one and a half percent per month or and ANNUAL PERCENTAGE RATE of eighteen percent. The finance charge on your account is computed by applying the periodic rate to the " overdue balance" of you account. The "overdue balance" of you account is calculated by taking the balance owed thirty days ago, and then subtracting any payment or credits applied to the account during that time.

REQUIRED PAYMENTS: any co-payments required by the insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

RETURNED CHECKS: There is a fee (currently $30) for any checks returned by the bank.

The Financial Policy continues on the next page.

Patient's name:_____

Responsible party's name:_____

Signature:_____

Date:_____

MISSED APPOINTMENT FEE: Our office hours are Monday through Friday, with appointments made exclusively for each patient. We recognize the value of your time. Except in the case of an emergency, you can expect us to be on time. We would appreciate the same courtesy. If for some reason you cannot make your appointment, we ask you to notify us 24 hours in advance. If you are not present on time for an appointment, or cancel with less than 24 hours notice, there will be a missed appointment fee. The charge will vary depending upon the amount of time scheduled for the missed appointment.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect on this debt. If we turn your account over to the court, you agree to pay all the court fees which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney's fees which we incur along with court costs. In case of suit, you agree the venue shall be in Gaston County, North Carolina.

WAIVER OF CONFIDENTIALITY: You understand that is this account is submitted to an attorney or the court, the fact that you have received treatment at our office may become part of public record.

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remain responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect for the other parent.

TRANSFERRING RECORDS: You will need to request in writing, and pay a reasonable fee (currently $22) if you want copies of records sent to another doctor. You must authorize us to include all relevant information, including you payment history. If you are requesting you records to be transferred from another doctor to us to receive all relevant information, including you payment history.

CONSENT FOR TREATMENT: I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs and any other diagnostic aid deemed appropriate by the doctor to make a diagnosis of my and or my dependents dental needs. Upon such diagnosis, I authorize the doctor and designated staff to perform all recommended treatment to provide proper care for myself or my dependents. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks.

TREATMENT OF CHILDREN AND MINORS: WE require a parent or legal guardian to accompany a minor child to their dental visit and to remain in the reception room throughout the course of their treatment. This insures the ability to communicate with the parent or guardian, while allowing us to develop a one on one relationship of trust and cooperation with the child.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.