PORTER DENTISTRY

CHAD PORTER D.D.S. & TONIA PORTER D.D.S.

1633 West Main Street, #200

Lebanon, TN 37087

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/or attorney fees. There is a $25.00 fee for returned checks. Payment is due in full at the time services are rendered.

Insurance Statement

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to Porter Dentistry or the Doctors.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received a Notice of Privacy Practices from the office of Porter Dentistry.

Cancellation Policy

Please give the office at least 48 hours notice if you are unable to keep your scheduled appointment. You may be charged a fee of $25.00 for failed appointments or failure to cancel an appointment with the appropriate notice.

Date: ____________________ **Signature:** ____________________________

Print: ________________________________