Madison Dental
Jason O. Gambrel, D.M.D.
308 Highland Park Drive
Richmond, KY 40475
Phone (859) 626-9851
Fax (859) 626-9854

FINANCIAL ARGREEMENT:
As our patient, we want to provide you the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good oral health, which are not covered by insurance. We reserve the right to bill insurance for all services rendered. You will be responsible to pay for all services not covered. **Co-payments are due at time of service.** I have read this policy and, by my signature, agree to pay for services not covered by my insurance as well as any legal and/or collection fees necessary for the collection of this debt. We reserve the right to apply an 18% annual finance charge and/or billing charge to any account that is not current.

Also, I understand that Madison Dental Associates reserves the right to turn any unpaid check over to a third party collection company in order to obtain payment on my behalf. I understand that they have the right to remove the amount written on the original check from my account. I will also be charged a Non Sufficient Fund Fee by, but not limited to, any of the following; Madison Dental Associates $30, my bank and the Re$ubmitIt program.

ACKNOWLEDGMENT OF RECEIPT:
I acknowledge that I have received and/or read a copy of Madison Dental Associates Notice of Privacy Practices.

ASSIGNMENT AND RELEASE:

I assign to Madison Dental Associates benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits including an insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

CONSENT FOR TREATMENT:

I give my consent for, Madison Dental Associates to provide treatment as they deem necessary. I will not hold anyone at Madison Dental Associates responsible in any way whatsoever regarding treatment that was performed. I acknowledge that by signing this form that I am assuming all responsibilities for every decision made while under the care of this facility

and all employees involved. I understand that there are risks involved with every dental procedure and by allowing anyone in this facility to perform any treatment, I assume all responsibility to the end result.

Weather Delay and Cancellation Policy:

I have been explained the weather delay and cancellation policy of Madison Dental Associates. I understand if I or a family member has an appointment and there are any weather related issues that prevent the doctor or staff from being able to safely enter the office that I have to option of checking all local news stations and calling the office voicemail to find any cancellations or delays in the opening of the office. I will not be charged a fee for the office being unable to be open, however I understand that it is my responsibility to know if the office has closed or delayed hours. If the office is open and I miss the appointment, then the Cancellation and Late Policy may apply.

The Signature below is acknowledgement of Hippa Consent, Cancellation and Late Policy, Consent for treatment, Weather Policy, Notice of Privacy Policies, Insurance Authorization and Release and Financial Policies of this office.

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Signature