PAYMENT IS EXPECTED AT THE TIME OF SERVICE

I understand and agree that regardless of my insurance coverage I am ultimately responsible for any and all charges incurred for my dental treatment. I agree to pay for any unpaid balances in a timely manner. I further understand that I will be responsible for any legal fees incurred in pursuing any unpaid balances, including court costs and attorney fees. Charges that are delinquent more than 90 days may be subject to legal processing. A fee of 30% of any unpaid balance may be assessed to your balance if your account is turned over for collection or legal processing.

I certify that all of the above information is correct and true to the best of my knowledge. I will inform York Dental Health Associates of any changes to my personal, medical, and/or insurance information.

Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICE:

Our practice provides this notice to comply with privacy regulations now imposed on all providers. It is our policy to keep all patient information confidential. Information needed by insurance companies to process claims will be released as necessary.

Any pertinent information needed by other healthcare providers will be released as necessary to insure proper care.

Signature:_____Date:_____