SMILE STUDIO
Michael J. Cushman, D.D.S.
3356 Fifth Avenue, Suite 100
Pittsburgh, PA 15213-3133

Acknowledgement of Receipt of Privacy Practices Notice

Name: _____

Address: _____

Phone: _____ E-mail: _____

Social Security Number: _____

I, _____, acknowledge that I received a Notice of Privacy Practices from the above named practice.

Signature & Date: _____

Financial Arrangements

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payments may be divided over the number of appointments. Cash, personal check, and credit card payments are accepted. If an extended payment plan is desired, please ask us about the Unicorn Financial Program. For fees of $500 or greater, a 5% courtesy will be extended for full payment in advance. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid, in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowance and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different from your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of ***allowable*** or ***UCR*** fees. All services are charged directly to the patient, and **the patient is ultimately responsible for the account regardless of insurance coverage**. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient. If you have any questions please feel free to ask.

Signature & Date: _____