Robert D. Arnold, D.M.D.

PAYMENT AUTHORIZATION FORM

Dr. Arnold is committed to meeting your dental needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all of our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from Dr. Arnold including those covered by my insurance. As a convenience, insurance claims will be submitted for payment to Dr. Arnold; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a deductible, a co-pay, and additional payment if it is determined that the cost of today's visit will not be reimbursed by my insurance provider.

3. Treatment may be denied for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, e-mail address, and insurance information at each appointment.

5. I agree to provide Dr. Arnold with my debit/credit card information. Failure of card authorization to go through will result in an additional $7 fee per failed transaction.

6. I understand that my signature and payment information will be maintained on file for future use, and the payment card or bank account number will be "tokenized" in order to help maintain the security of my payment information.

7. I understand I may have the option of paying my costs via an automated payment plan.

8. I authorize Dr. Arnold to apply charges to my payment card and/or bank account for all amounts owed for procedures performed including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) amounts not covered by insurance and/or (v) fees charged for failure to keep a scheduled appointment or provide 24-hours notice of appointment cancellation. A minimum of $25 per month will be charged for balances less than $300, and a minimum of $50 per month will be charged for balances above $300 will be charged until the patient's financial responsibility has been fully paid.

9. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

This authorization will remain in effect until I provide written notice of cancellation to Dr. Arnold. I understand that I can cancel the authorization only for future treatment. Authorization for treatment already rendered cannot be cancelled or refunded.

I agree to notify in writing of any changes in my payment or other information.

Cardholder's Name as it Appears on Card: _____
LAST FIRST MIDDLE

Cardholder's Billing Address: _____
STREET CITY STATE ZIP

Mobile Telephone Number: ( ) -

Home Telephone Number: ( ) -

Cardholder's Email Address: _____

Cardholder's Signature: _____ Date: _____