ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

Please initial each section, print name, sign and date at bottom

_____ In consideration for the professional services to be rendered to me, (or at my request, to my dependent) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. Accounts 60 days overdue will incur a 5% late fee. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency (25%) to which a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary.

_____ I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

_____ I grant my permission to the Practice to telephone me at home, on my cell phone or at my workplace to discuss matters related to this form. I also agree to let the Practice leave messages concerning appointments and/or results on my answering machine or with a family member.

_____ I agree, in order to service my account or to collect monies I may owe, representatives of Jason P. Tosto, DMD, and/or agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also be contacted via text message or email, using any email address I have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

_____ I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I acknowledge that I may receive a copy of the Practice's Privacy Policies, if desired. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care. I understand and agree to this Financial Policy and Agreement, and agree to be fully responsible for total payment of treatment performed by the Practice.

BY SIGNING BELOW, YOU CERTIFY THAT YOU HAVE READ THIS AGREEMENT, THAT YOU KNOW AND UNDERSTAND THE MEANING AND INTENT OF THIS AGREEMENT AND THAT YOU ARE ENTERING THIS AGREEMENT KNOWINGLY AND VOLUNTARILY.

Patient/Guardian Name_____ Date_____

Patient/Guardian Signature_____