



HONEA FAMILY DENTISTRY
10015 HWY 280 • WESTOVER, AL 35147

FINANCIAL AGREEMENT

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. 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.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received and/or read a copy of Dr. Todd A. Honea Notice of Privacy Practices.

ASSIGNMENT AND RELEASE

I assign to Dr. Todd A Honea 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. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

The Signature below is acknowledgement of HIPPA Consent, Notice of Privacy Policies, Insurance Authorization and Release and Financial Policies of this office.

Patient's Name (Please Print)

Signature (Patient/Parent/Guardian)

Date

Todd A. Honea, DMD