**232 19th Street NW Suite 7200**
**Atlanta, GA 30363**

**<u>IF YOU WISH FOR US TO FILE DENTAL INSURANCE PLEASE NOTIFY THE FRONT DESK COORDINATOR SO THAT WE CAN OBTAIN THE INFORMATION NECESSARY TO FILE FOR YOU.</u>**

The undersigned understands that insurance coverage **DOES NOT RELIEVE** him/her of the responsibility of payment of the entire account if third party payment is not received. **Estimates given by our staff are not guarantee of insurance payments** as these third parties will not guarantee payments. Estimates are based on information we have at the time regarding your coverage.

The undersigned is responsible for payment of services rendered in addition to the head of household. If the patient is a minor, BOTH parents are responsible. If the undersigned is not the patient, it is understood the patient is also responsible for payment of services provided for him/her. I/We agree to pay the amount invoiced in full. The applicant agrees that 19th Street Dental may assess interest and service charges on the outstanding balance at the rate of 1.5% per month (18% per annum). I/We further agree to pay all costs of collection, including costs of a collection agency if the account is turned over to a collection agency, and including 15% attorney's fees and court costs in the event this balance is turned over to an attorney. It is agreed that this agreement will be governed under the law of the state of Georgia. 19th Street Dental has the option of pursuing an action under this agreement in any court of competent jurisdiction in the state of Georgia and I/We consent to jurisdiction in the state of Georgia. If my/our business is a corporation, **I/We agree to be personally responsible as guarantor for any debt made by the corporation. I/We have received a copy of this agreement.**

If an account is not paid at the time of service 19th Street Dental is authorized to obtain a report from a credit reporting agency regarding my credit history.

PLEASE GIVE THE RECEPTIONIST A PHOTO IDENTIFICATION CARD when you have completed this form.

| ______________________________ | __________ | ______/______/______ |
|---|---|---|
| PATIENT, PARENT OR GUARDIAN (AS APPROPRIATE) | DATE | Social Security Number |

*****MEMBER EQUIFAX CREDIT REPORTING SERVICES*****

**As required by law, you are hereby notified that a negative credit reporting reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations.**