William M. Sergakis, D.D.S.
7240 S. Highland Drive Suite 102
Salt Lake City, UT 84121
(801)733-0864

Office Policy and
Truth-in Lending Statement (Please Read):

As a condition for your treatment in this office, ALL financial arrangements must be made in advance. Patient co-payments (those fees NOT covered by insurance) and deductibles are due and payable at time of service.

All emergency dental services or any dental services performed without previous financial arrangements must be paid at the time services are received.

For patients who carry dental insurance, it is understood that all dental services, received are charged directly to you, the patient or to a parent/guardian in the case of a child, and that he/she is personally responsible for payments of all dental services. Our office will assist you in preparing the proper insurance forms or assist in collecting from insurance companies, and subsequently crediting any and all such collections to your patient account. Please understand that this dental office will not tender services on the assumption that our charges will be paid fully by an insurance company.

A service charge of 1.5% per month (18% annually) on any unpaid balances will be added on all accounts exceeding sixty days from date of service. Accounts with unpaid balances over 90 days will automatically be referred to an outside collection agency. Fee estimates for any dental care will only be extended for a period of six (6) months from the date of your dental examination or consultation.

In consideration for the professional services rendered to me, or at my request or permission for my minor child or ward by the dentist, I agree to pay, the reasonable v1llue of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing, if credit is extended. I further agree that the reasonable values of said services shall be billed unless, objected to by me, in writing, within the time, for payment thereof. I further agree that a waiver of any breach of any term 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 and court costs, if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of the principal) that may be asses by any collection agency retained to pursue this matter.

I grant my permission to you or any, of your assignees to contact me at my home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or any family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. William M. Sergakis, D.D.S.

I hereby agree to abide by the conditions outlined therein.

PLEASE SIGN BELOW

_____	_____	_____
Signature or Patient, Parent or Guardian	**Date**	**Relationship to Patient**

_____

Please Print Name