PATIENT RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by the dental office of **W. MICHAEL TUMAN, D.M.D., P.C.** (also called the "Office"), according to the policies stated in this Patient Responsibility Agreement.

TREATMENT PLAN. I acknowledge that I am financially responsible for all patient services, including services which may be itemized in the Treatment Plan which is attached as Exhibit A, as amended from time to time.

PATIENT INFORMATION. The patient information provided to the Office is true and correct. I will notify the Office about any significant future revisions to the patient information furnished.

INSURANCE. If I expect my insurer to cover some or all of the cost of the patient services, the Office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. I agree to cooperate and provide all information necessary to the Office. However, I have the primary relationship with my insurer and the Office is not responsible for guaranteeing that benefits will be received in the amounts and in the time-frame as requested. **I am responsible to resolve any problems with my insurer**. I may request that the Office obtain a pre-estimate of insurance benefits before patient services are performed.

PAYMENT SCHEDULE. Unless my treatment is scheduled over a period of time, and unless I specifically request, and the Office approves in advance, a payment schedule for the patient services, **all payments for services are due when a billing statement is presented after the services are performed**. The Office will not otherwise approve any deferred payment schedule.

BILLING STATEMENT. It is possible that portions of the bill for patient services, such as co-payments, deductibles and exclusions, may not be paid by the insurer. Those unpaid portions must be paid by me when a billing statement is presented after the patient services are performed. Payments may be made in cash, check or by credit card. If my insurer has not paid the benefits to the Office within 90 days after submitted, the Office may then require me to pay for the patient services in full, and any insurance benefits later received by the Office will be returned to me.

REFERRAL FOR COLLECTION. If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The Office may deny subsequent patient treatment if my account balance remains unpaid.

ACCOUNT CHARGES. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1 1/2% per month (18% annually).

ACCOUNT ADJUSTMENT. If I fail to make a co-payment by the date required by my insurer, if applicable, then my account can be adjusted and I would be responsible for the full amount due for the patient services rendered.

FAMILY RESPONSIBILITY. I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my family members, regardless of ages, unless I notify the Office in writing otherwise.

COLLECTION FROM OTHERS. If I am financially indigent and unable to pay for patient services rendered, the Office may seek to recover my account balance from certain of my adult relatives under applicable Pennsylvania law.

CANCELED APPOINTMENTS. If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of $25.00 per ½ hour.

RETURNED CHECKS. If my check is returned by the bank, I can be assessed with a processing charge of $20.00.

Dated: _____

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Patient or Responsible Party Signature