Financial Arrangements

I _________________________________ (name) authorize Dr. Grosso to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to a third party. I authorize and herby request my insurance company to pay directly to Dr. Grosso insurance benefits otherwise payable to me. I understand that my dental insurance can or may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

If I do not keep my account current by paying each month, a late charge of 1.5% per month (18% per annum) on any unpaid balance will be due and owing from the date services are rendered or goods provided until paid in full.
I realize the failure to keep this account current may result in Dr. Grosso being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay all collection costs including but not limited to 50% attorney fees on any unpaid balance from the time my account is placed with an attorney for collection.

I understand that Dr. Grosso may assess a $100 cancellation fee for any appointment cancelled within twenty-four hours of said scheduled appointment and a bank charge of $25 for any checks returned for non-sufficient funds or stop payment.

Patient or Responsible Party ____________________________________

Printed Name ____

Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. Michael E Grosso's Notice of Privacy Practices.

Patient or Responsible Party ____________________________________

Printed Name ____

Date ____________________