Responsible Party Agreement

I am requesting that dental services be rendered by Patricia Gardner Webb, DMD, PhD, and/or Jordan T. Webb, DMD of Gentle Dental Care. In consideration of this, I understand and agree to the following:

I acknowledge and accept full responsibility for the payment for dental services rendered to me. I understand and agree that I will pay for these services in full at the time they are rendered. If the dentist elects to bill me by statement, I understand and agree that this will not constitute an extension of credit. If I am agreeing to guarantee payment in consideration of dental services rendered to someone other than myself, I agree to sign the guarantor's agreement included on this page and to be bound by its terms and the terms of this agreement.

I understand and agree that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees incurred. These fees are due and payable at the time of service unless prior financial arrangements have been made. If I need financial arrangement I understand that I have to have them approved prior to services. I further understand and agree to allow the above to review my credit history if I request financial arrangements. I understand and agree that it is my responsibility to pay any deductible amount, co-payment, or any other balance not paid for by an insurance company whether or not I feel the insurance carrier is liable and that any such amount is fully due and payable at the time services are rendered.

I understand and agree that if it becomes necessary to assign this account to a collection agency the costs of collecting my account will be added to my past due balance, and I will then be liable for the additional amount. If this account is placed with an attorney for collection and/or suit in a court of law, the prevailing party shall be entitled to reasonable attorney and/or agent fees and the cost of collection.

I understand and agree that if I make a payment by check and the check is dishonored, I will be assessed a service fee of $35.00. I further understand that a service charge will be added to any overdue balance.

I authorize the dental physician to release all medical information necessary for the purpose of securing payment from insurance companies. For this purpose, a photocopy of this signature is as valid as an original. Any payments received by the Doctor from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees in full.

Signed_____Date_____

GUARANTOR'S AGREEMENT

I guarantee payment in full on demand for any and all charges in consideration for dental services rendered to the person named above by the dental physicians of Gentle Dental Care commencing on _____20____. I also agree to be bound by the terms of the agreement as stated above.

By_____ Address_____

Dated_____ City/State_____

Relationship to patient_____ Telephone_____

Employer_____ Work Telephone_____