GENE C. MEARS D.D.S.

Medical Arts Building, Suite 104
2301 Fall Hill Ave., Fredericksburg, VA 22401
Phone: 540/373-7901 | Fax: 540/310-4849

Office of Dr. Gene C. Mears
PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Birth Date:_____ Soc. Sec.#:_____ Drivers Lic.#:_____

Email:_____

Responsible Party information if patient is a minor or has a guardian

First Name:_____ Last Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Birth Date:_____ Soc. Sec.#:_____ Drivers Lic.#:_____

How did you hear about our office? [ ] Patient Referral [ ] Phonebook [ ] Internet [ ] Other

We are dedicated to your treatment and take pride in the quality of care that we deliver. In order to avoid misunderstandings, we provide the following information:

As a courtesy to you, we will file most insurance claims. However, your insurance coverage is an agreement between you and your insurance company. We do not necessarily accept insurance company allowances as full payment for your account. Due to the volume of claims filed by our office, we are unable to follow up on unpaid or unprocessed claims.

After **60 days**, any unpaid insurance claims become your full responsibility. Since insurance policies vary greatly, it is **your** responsibility to contact your insurance company if you have any questions regarding your policy, claim and to make sure your claims have been paid.

Payment is required at the time of service. We accept cash, personal checks, Visa, MasterCard or Care Credit. A **$25 fee** will be collected for all checks returned by the bank. **A handling fee of 1.5% or $5** (whichever is greater) will be applied to balances that require billing. This charge will be applied each month until account has been paid in full. The undersigned agrees to pay a fee for any missed appointments or appointments cancelled when less than one working days notice is given for a fee of **$45 per 30 minutes** of scheduled time. Insurance companies **will not** pay missed appointment fees.

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay **18% interest** per year on all balances which are unpaid **60 days** after the services are rendered. All accounts due over **90 days** will be sent to Collections. The patient or his/her legal guardian is responsible for all charges made for treatment rendered by Dr. Mears and Staff. If a collection agency, lawyer or other party is used to assist in collection of the account, any and all charges and fees made by these people, agencies or courts will be added to the patient's account.

In absence or prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney or collection agency for collection. These companies will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I [ ] **am** [ ] **am not** an active duty member of the U.S. Armed Forces.

_____ _____

Date Responsible Party Signature