FAMILY & COSMETIC DENTISTRY

B. Jack Friend, II D.D.S.

15806 JEFFERSON DAVIS HWY ● S. CHESTERFIELD, VA 23834 ● (804) 520-8994

Policy and Assignment of Benefit

1. Cancellation Policy: Our office requires at least 24 hours notice if you must cancel an appointment or a $25.00 fee for the appointment time and appointment preparation may be charged.
2. Agreement to Assign Benefits:
   I hereby authorize Dr. Jack Friend, II, D.D.S., to furnish information to insurance carriers concerning my treatment and I hereby assign to dentist all payments for dental services rendered to me or any of my dependants. I understand that I am responsible for any amount not covered by my insurance. If this contract for service is unpaid and referred to our collections agency for collection, that I agree to pay thirty-three and one third (33 1/3%) percent in collectors fees, plus interest in the amount of eighteen (18%) for the last date of service per annum, a one and half percent (1.5%) service charge per month and court and any collection cost used to collect the outstanding debt.
3. I understand that it is my responsibility, as policyholder, to contact my insurance company regarding payments of my claim. If payment has not been received from my insurance company within sixty (60) days, I will be billed for the total amount due and will be held financially responsible for payment.

Signature: _____ Date: _____