Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist 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 third party payers and/or other health practitioners.

Late Charges

All unpaid balances 30 days or older will be assessed a late fee of 1.5% each month. I understand that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies. If additional services are needed, prepayment may be required prior to scheduling. In the event of default on payment of this account, I agree to pay all collection costs and all attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Further, I agree that the construction and interpretation of this document shall at all times and in all respects be governed by the laws of the State of Louisiana. Any dispute arising out of this document, or any sales or services of the clinic, including the collection of any unpaid fees and enforcement of any judgement, may be litigated and/or enforced in the 2nd Justice Court, Parish of Ascension, State of Louisiana, and I do hereby personally consent to the jurisdiction and venue of said court.

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Dr. Bailey and his associates to discuss my condition with my physician and to request medical information from him. I authorize the office of Gray Bailey, DDS or his agent to obtain and verify a credit report.

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Signature of Responsible Party Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.