



JEFFREY M. GREENHILL, D.D.S., P.A.

I hereby request and give permission to Dr. Jeffrey Greenhill and whomever he may designate as his assistant to administer treatment and to perform such general procedures as he may deem to be necessary in the diagnosis and treatment of my dental needs.

I further authorize payment of insurance benefits to Dr. Jeffrey Greenhill for the services he performs.

I also understand that I will be responsible for any deductibles, co-pays or non-covered services. I understand that payment is expected at the time of service that is rendered, unless specific and special arrangements are made prior to the appointment.

I further understand that in the event of default, I am responsible for the service rendered. In the event that your account is placed with a Collection Agency, a collection-fee in the amount of 30% of the then outstanding balance will be added to your account and shall become part of the Total Amount Due.

If your account is subsequently placed with an Attorney for legal action, whether suit is actually filed or not, attorney fees will be added in the amount of 25% of the balance as of the date of placement with the attorney (including collection fees of 30% and shall become part of the total amount due.

These authorizations shall be as effective and valid as the original and shall remain in effect.

Name of patient (Print) _____

Relationship to Patient _____

Signature of Patient _____ Date _____