Kim E. Stiegler, D.M.D.
1151-A Hillcrest Road
Mobile, AL 36695
(251) 639-1853

Patient's Name ___________________________________

I____ agree to pay all dental services rendered to the above named person even though I may have insurance or other third-party coverage. I recognize that the cost of this dental care may exceed the amount reimbursed by my insurance company. I understand that the payment for services is due when services are rendered and when appropriate a credit report may be obtained. Any account not paid within 30 days may be subject to a statement fee of $3.00 or one & one-half percent per month (18% annual percentage rate). I also understand that any scheduled appointment broken or canceled without 24 hours notice may be subject to a charge up to $100.00 for each 1/2 hour of missed appointment time. The undersigned hereby agrees to pay all costs of collecting, or securing, or attempting to collect or secure any indebtedness of the undersigned to Dr. Kim Stiegler including a reasonable attorney's fee, whether the same be collected or secured by a suit or otherwise. I also give consent to have photographs taken. I understand that these photographs may be used for scientific publication and/or educational purposes

CAUTION: IT IS IMPORTANT THAT YOU THOROUGHLY READ THIS AGREEMENT BEFORE YOU SIGN.

Signed:____________________________

Date:_____________________________

FOR PATIENTS WITH INSURANCE:

I hereby authorize payment directly to the above named dentist of the insurance benefits otherwise payable to me.

_________________________________ _________________________

Insured's Signature Date