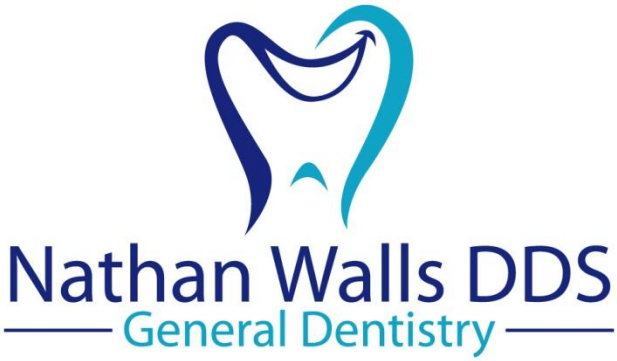

I UNDERSTAND THAT FEES MAY VARY AT THE TIME OF SERVICE DUE TO THE EXTENT OF TREATMENT. FEES ARE ESTIMATES ONLY AND ARE NOT GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY. I UNDERSTAND THAT PAYMENT OF THIS ACCOUNT IS MY RESPONSIBILITY REGARDLESS OF THE AMOUNT MY INSURANCE COMPNAY PAYS FOR MY DENTAL SERVICES. I UNDERSTAND THAT NATHAN WALLS DDS WILL ONLY BILL MY PRIMARY INSURANCE AND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY DENTAL PLAN, AND THAT AFTER 90 DAYS; THE BALANCE WILL KNOWINGLY BE TURNED OVER TO COLLECTIONS. I CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT PAYMENT ACTIVITIES IN CONNECTION WITH THIS CLAIM. I HEREBY AUTHORIZE PAYMENT OF THE DENATL BENEFITS TO BE MAILED DIRECTLY TO THE ABOVE NAMED DENTIST OR DENTAL FACILITY. I ALSO UNDERSTAND THAT THIS OFFICE HAS A CANCELLATION POLICY CONSISTING OF A $25.00 CHARGE TO MY ACCOUNT IF I CANCEL APPOINTMENTS WITHOUT PRIOR 24 HOUR NOTICE- EXCEPTINS MAY BE ALLOWED AFTER REVIEW BY OFFICE MANAGER.

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PATIENT/PARIENT OR GUARDIAN SIGNATURE DATE