

*Linda J. Ruppel, D.D.S*  
*Prosthodontist*  
*Certificate in Geriatrics*

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Mo. Day Year

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Responsible Party \_\_\_\_\_ Birthdate \_\_\_\_\_ S.S. \_\_\_\_\_

Mailing Address (if different than above) \_\_\_\_\_

Telephone-Home \_\_\_\_\_ Work \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Policyholder \_\_\_\_\_ Group# \_\_\_\_\_

Referred by: Yellow Pages \_\_\_\_\_ Regional Directory \_\_\_\_\_ Friend \_\_\_\_\_ Doctor \_\_\_\_\_  
Other \_\_\_\_\_ Name \_\_\_\_\_ Name \_\_\_\_\_

In Emergency Notify \_\_\_\_\_ Telephone \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

**FINANCIAL AGREEMENT**

1. I Agree to pay the amount charged by the doctor for all professional treatment and services to myself, my family or the person indicated on this form. Payment to be made by me (responsible party) to Linda J. Ruppel, D.D.S.
2. Payment to be made in full, at time of service by: \_\_\_\_\_ cash \_\_\_\_\_ check \_\_\_\_\_ credit card \_\_\_\_\_ assigning insurance benefits and paying your portion (co-payment and/or deductible) at the time of service.
3. In the event that I do not pay at the time of service, I authorize this office to verify my good credit rating.
4. All unpaid balances are subject to a monthly FINANCE CHARGE of 1.5% (annual percentage rate of 18%) or a minimum of \$5.00 per month.
5. In the event that emergency services are performed, I agree to pay in full at the time of service.
6. In the event of non-payment by me resulting in the dentist referring this account to an attorney or collection agency, I agree to pay and indemnify the dentist against all legal costs and charges including but not limited to reasonable attorney fees, court costs, disbursements and collection agency charges incurred by the dentist.

Declaration-I have read and I understand the Financial Agreement on this form. I also verify that the information given is true.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
person responsible for payment