Barney E. Selph, D.D.S., Ltd.

726 Randolph Avenue

P.O. Box 88

Cape Charles, Virginia 23310

(757)331-1589

FINANCIAL AGREEMENT AND CONSENT FOR TREATMENT

The patient below has been received for treatment and has been accepted as a patient by Dr. Barney E. Selph, D.D.S. In consideration of the Doctor's undertakings, the undersigned agrees to pay all charges made by the Doctor for the care and treatment of the patient.

The undersigned acknowledges that the Doctor is not in the business of extending credit and promises to pay the Doctor's charges at the time services are rendered, unless other terms have been agreed to in writing. If prompt payment is not made, the undersigned understands that the Doctor may immediately take action to collect his charges, in which event the undersigned agrees to pay all costs and expenses incurred by the Doctor, including but not limited to attorneys fees in the amount of 33 1/3 percent of the total amount of the charges, plus any interest accumulated at the rate of 2% per month (not to exceed the lawful rate) from the date of service. In addition, any collection fees which are incurred by the Doctor would also be recoverable from you in the event that this matter is forwarded to a collection agency.

If the patient has or claims to have insurance to pay all or part of the Doctor's charges, the Doctor may agree, upon terms acceptable to him, to submit or assist the patient in submitting claims to the insurer as a courtesy to the patient, but the Doctor is not obligated to do so unless he is under contract with the insurer. Patient will pay any deductible and /or co-payment amount due at time of treatment. Any proceeds of insurance paid to the Doctor will be applied to the patient's account. The undersigned will be responsible for prompt payment of the balance of the account. The undersigned agrees that over payment of a claim will result in those funds being credited to any outstanding balance owed to Doctor.

All payments should be submitted to Dr. Barney E. Selph at P.O. Box 88, Cape Charles, VA 23310. Methods of payment are: cash, check, Visa, Master Card, and Discover. A $25.00 returned check fee will be added to the patients account for all returned checks.

CANCELLATION POLICY: A 24 hour notice is required to cancel appointments. A deposit will be required if a patient misses or cancels three consecutive appointments without proper notification.

MEDICAL AND SURGICAL CONSENT: The undersigned hereby gives consent to the Doctor or any assistant who they may call to their aid, to administer any treatment and especially to administer anesthesia and to perform such procedures upon the patient as they in their judgement, prior to or during the procedure, may deem advisable in the care and treatment of the patient's case. The undersigned authorizes the Doctor to retain or dispose at his convenience any specimen or tissue taken from patient's body during treatment.

ACKNOWLEDGMENT FOR AIDS TESTING: The undersigned understands the possibility exists that during treatment, health care workers may be directly exposed to patient's body or blood fluids. In the event of such direct exposure in a manner which may, according to the Center for Disease Control Guidelines, transmit AIDS (Acquired Immune Deficiency Syndrome), a sample of patients blood may be tested for the presence of infectious diseases such as hepatitis, syphilis, and AIDS. I further understand that the results of the test will be released to me and any health care worker who has suffered an exposure.

RELEASE OF INFORMATION: The undersigned gives permission for Doctor and his staff to release to any insurance company having insurance on patient such information as requested.

I agree with the terms set forth herein:

Date Patient Guarantor Relationship to Patient