MEDICAL SERVICE CONTRACT
DR. MARCEL G. LAMBRECHTS, JR. DDS PLLC

Patients Name:____

I hereby authorize the release of medical information to any of my healthcare providers or insurance companies that may be pertinent to my case. I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other persons to whom disclosure is necessary to establish or collect a fee for the services provided.

I understand I am financially responsible for all charges arising for the treatment of myself (or the above named patient if applicable). I understand that payment is due in full at the time the services are rendered; however, I agree to pay a FINANCE CHARGE of 1.5% per month on balances over (30) days past due, which is an ANNUAL PERCENTAGE RATE of 18%. Furthermore, I understand there is a charge of $50.00 for each broken appointment. Appointments are considered broken if ***less than 24 hour notice*** is given without ***reasonable cause.*** After three broken appointments any broken appointment will be charged $50.00 **regardless of cause.**

If my account is referred to an attorney for collection, I agree to pay all collection and court costs, including attorney's fees in the amount of thirty-three and one third percent (33 1/3%) of the total indebtedness then due.
A photocopy of this contract shall be considered as valid as the original.

Signed ____
(Patient or Responsible Party)