OFFICE FINANCIAL POLICY

Patients that will be on the account _____ _____

_____ _____ _____

To our patients with no dental insurance, we request that payment in full is made at the time services are rendered.

FOR PATIENTS WITH DENTAL INSURANCE

Insurance Company_____ Group #_____

Insurer's SS#_____ Insurer's Date of Birth_____

Insurer's Employer_____

Please remember that no insurance company covers all dental cost. We will file your insurance as courtesy to you. We will make every effort to ensure that is done promptly and properly. Payment of all deductibles and co-payments are due on the day of service all amounts not paid by your insurance company are your responsibility. A copy of your ID card must be on file in the office.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dental office. I authorize the release of any information related to this claim. I understand that I am responsible for all costs of dental treatment.

If you find that you are unable to keep an appointment please call the office 48 hours in advance. The office will charge for all missed appointments. These charges are not covered by any insurance.

All fees are due on the day of treatment unless other arrangements have been made in advance. All accounts overdue more than 30 days are subject to a 1.5% per month finance fee (18%APR). If collection action becomes necessary for non-payment, a collection fee of 35% will be included for attorney fees, this will be the responsibility of the patient (or parent, if patient is a child).

SIGNATURE_____ DATE_____

Referral Information
Please tell us how you heard about our office_____