

FINANCIAL INFORMATION

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X _____ Date _____
Signature of Patient or Parent if Minor

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer. While we do file insurance as a convenience for you, we require payment in full of the uninsured portion/patient co-pay.

_____ Cash
_____ Check
_____ Credit card
_____ I wish to discuss the office financial policy

LATE CHARGES

If an entire account balance is not paid within 30 days of the monthly billing date, a late charge of 1.5% or a minimum of \$10.00 on the balance then unpaid and owed will be assessed each month.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding or any future outstanding account balances.

WELCOME TO OUR OFFICE AND THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. IF YOU HAVE ANY QUESTIONS AT ANYTIME, PLEASE ASK. WE ARE ALWAYS HAPPY TO HELP.