

PAYMENT OPTIONS

To help keep cost of dentistry down and to continue to provide quality care to our valued patients, we now only accept payment in full the day of treatment.

I authorize Westford Dentistry to keep my signature on file and to charge my credit card, from time to time, as the Dental office deems necessary, to settle my account in full.

Please check mark the option(s) most convenient for you to settle your account in full today.

Patient Name: _____

Card holder Name: _____

Cash/Check

VISA Acct# _____ Exp. Date _____

MC Acct# _____ Exp. Date _____

AMX Acct# _____ Exp. Date _____

DISC Acct# _____ Exp. Date _____

Care Credit (Please see receptionist for Application Form)

I assign my insurance benefits to provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

(Patient Name)

(Date)

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