DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we are happy to accept assignment of your insurance benefits and do the insurance work for you. We do ask that all patients who pay the *ESTIMATED* co-pay and have us wait for their insurance payment leave a credit/debit card number confidentially on file with us. We will keep this card information on file to cover any unpaid balances from your insurance that are $99.00 or less. **We will contact you prior to charging your card.** We will allow 5 days after initial contact for you to respond to this matter and make other financial arrangements. If we do not hear from you on the sixth (6th) day your card will be charged for the full amount. If you are unable to leave a credit/debit card on file, then ask our financial coordinator for more details on our other payment options, such as, Care Credit financing. While we are pleased to be of service by processing your dental claim for you, we are not responsible for any limitations in coverage that may be included in your plan. If your dental plan denies a claim for any reason, you will then become responsible for your bill in its entirety. It is your responsibility to pay any amounts in full.

Our primary mission is to provide you with excellent, comfortable and efficient dental care. Together we are advancing to more efficient ways that dental care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best dental care available.

I have read and understand my obligations and I acknowledge that I am responsible for payment of any services not covered by my insurance carrier.

____ ________________________
Print Name Date

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Patient Signature

DEBIT/CREDIT CARD PRE-AUTHORIZATION

□ Visa □ Master Card □ Discover □ American Express □ Care Credit

Account Number: ____________________________ Exp. Date: __________ 3-Digit Code: _________

Patient Street Address: __________________________________ Zip Code: _______________

** ***NO I DO NOT AUTHORIZE*** you to charge my credit card for any balances. I understand that by not leaving a credit/debit card pre-authorization on file, I will be required to pay in full for any and all treatment, and will then be reimbursed directly from my insurance company. **

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Patient Signature Date