PAYMENT ARRANGEMENT FORM

Our goal is to provide the highest quality dental care possible and to have clear communication of our financial policy.

NAME OF PATIENT:_____ ("Patient")

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental, and accident insurance policies are an arrangement between my insurance carrier and myself. I agree to pay all deductible and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company AS MY INITIAL PATIENT PORTION TODAY IS ONLY AN ESTIMATE. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.

_____ I understand that the Practice may charge the following items:

1. A $35 fee for each appointment that is missed/cancelled without at least 24 hours advance notice.

2. An amount equal to $35.00, but not to exceed that maximum amount permitted by law for each returned check.

3. A $99 fee for any 3D that is copied to a disc and released in your behalf.

4. Any account past due over 30 days is subject to 2% interest per month until balance paid in full.

I agree to the extent permitted by law, to pay court costs and attorney fees on any amounts that are litigated and I will pay a 50% collection fee on any amounts past due that is turned over to a licensed collection agency. I understand that if treatment or care is suspended at any time by the Patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the practice.

RESPONSIBLE PARTY:

Full Name:_____ **DOB:**_____ **SSN#:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____

Employer Name:_____

INSURANCE INFORMATION:

Primary Insurance Name:_____ **Address:**_____

Name of Insured:_____ **Relationships:**_____

ID Number:_____ **Group Number:**_____ **Phone:**_____

SECONDARY INSURANCE:

Secondary Insurance Name: _____ **Address:**_____

Name of Insured:_____ **Relationship:**_____

ID Number:_____ **Group Number:**_____ **Phone:**_____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ **Date:** _____