

## FINANCIAL INFORMATION FORM

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### PATIENT INFORMATION

Name _____		Male ____	Female ____
Address _____			
E-mail address _____			
Date of Birth _____	Telephone#s _____	home _____	work _____
		cell _____	
Place of Employment _____	Occupation _____	Soc. Sec. # _____	

### GUARANTOR OF ACCOUNT

(if other than the patient)

Name _____		Male ____	Female ____
Relationship to Patient _____			
Address _____			
E-mail address _____			
Date of Birth _____	Telephone#s _____	home _____	work _____
		cell _____	
Place of Employment _____	Occupation _____	Soc. Sec. # _____	

## DENTAL INSURANCE INFORMATION

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
Company _____	Company _____
Group # _____	Group # _____
Claims Address _____	Claims Address _____
_____	_____
Company Toll Free Phone # _____	Company Toll Free Phone # _____
Policy Holder's Name _____	Policy Holder's Name _____
Date of Birth _____	Date of Birth _____
SS # _____	SS # _____
Employer _____	Employer _____

# FINANCIAL RESPONSIBILITY

Thank you for choosing us as your dental care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

▪**PAYMENT:** Fees for services are due when treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer financing through Capital One or Care Credit.

▪**INSURANCE:** With documented evidence of coverage, i.e. an insurance card, this office will submit claims for the insured party to be reimbursed for services rendered. We do not accept assignment of benefits. The amount of reimbursement is determined by the insurance carrier. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim.

▪**THIRD PARTY PAYMENT:** If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.

▪**NON-PAYMENT:** In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

▪**RETURNED CHECKS:** A \$25 processing fee will be charged for a returned check.

▪**INTEREST:** Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance (18% per year) unless prior payment arrangements have been approved.

▪**CANCELLATION:** Patients are expected to notify the office at least 48 hours prior to their scheduled appointment if they cannot keep the appointment. Failure to properly notify the office will result in a charge of \$50 for the missed appointment. Three non-notified missed appointments may result in dismissal from the practice.

## FINANCIAL RESPONSIBILITY AGREEMENT

I have read the financial responsibility for periodontal services, agree to the terms and accept full responsibility for all charges for services rendered.

Patient/Authorized Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to

Patient: \_\_\_\_\_