Anita W. Elliott, D.D.S., P.C.

Financial Policy—

PATIENT NAME _____
INSURANCE PROGRAM_____**EMPLOYER**_____
PERSON RESPONSIBLE FOR ACCOUNT_____

FINANCIAL ARRANGEMENTS

I consent to and authorize the indicated dental services to be performed. I understand, and agree to pay the fees associated with the dental treatment as indicated below:

PAYMENT IN FULL at each appointment for dental treatment prescribed by:

_____**Cash** _____**Personal Check**

_____**Credit Card: Visa, MasterCard, Discover, American Express**

Account Number _____Valid Dates _____/_____

IF YOU HAVE TRADITIONAL INDEMNITY INSURANCE it is YOUR responsibility to furnish us with correct insurance information. Due to constantly changing insurance regulations, benefits and deductibles, we are only able to approximate your insurance coverage. As a courtesy to you, we will submit necessary forms, and wait 45 days for payment. If your insurance pays more than expected, you will be reimbursed the difference. If your insurance pays less than expected you will be personally responsible and will be billed the difference allowed.

Insurance Authorization: I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dentist. Any deductible, co-payment, or fee not covered by my insurance may be billed to me, and I agree that I am personally responsible for any remaining balance.

I authorize Anita W. Elliott, D.D.S., P.C., or Elliot Dental Corporation to keep my signature on file and to debit the credit card below for any outstanding balance of charges not paid by my insurance or by me within 60 days of treatment, and not to exceed $1,500.00 per debit.

Cardholder Name _____ Cardholder Signature_____

Account Number _____Valid Dates _____/_____

OUR POLICY I understand that I am personally responsible for all costs of dental treatment, and for all dental fees billed. If for any reason I do not pay the entire New Balance within 15 days of the monthly billing, a FINANCE CHARGE may be added to the account for the current monthly billing period, which is an APR OF 18% applied to the last month's balance. I understand that in the event a payment is past due, and I have not contacted the Dental Office within 30 days, I will be considered in default, and my account will be given to an agency or attorney for collection. If my account is referred for collection, I will be responsible for all fees and costs including all costs of collection. This office reports to all credit bureaus.

There will be a charge for each broken appointment if 24-hour notice is not given.

Treatment estimates are guaranteed for 30 days from the date the estimate is made.

Patient Signature _____**Date** _____