PERSONALIZED & COMFORTABLE
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Insurance Information

Please report your insurance information to one of our front desk personnel who can help you determine details about your coverage. If your insurance company has provided you with a card that has a group number and ins. co. telephone number, please provide that as well.

Authorization and Release

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option you prefer.

❑ Cash ❑ Personal Check ❑ Credit Card (Visa, Mastercard, American Express or Discover)

All balances are due within 30 days of billing. I understand that if I do not pay the entire amount due within 30 days of the monthly billing date a late fee of 1.5% on the unpaid balance may be assessed each month. I realize that any failure to keep my account current may result in Mt. Scott Family Dental being unable to provide additional services, except for dental emergencies or where there is prepayment for services.

X ____

Signature of patient or parent if minor Date

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