PATIENT INSURANCE INFORMATION

Patient name: _____ DOB: _____

Responsible Party: _____

Primary Insurance

Policy Holder Name: _____ SS#: _____

Insurance ID #: _____ Group #: _____ DOB: _____

Employer: _____

Dental Insurance Company: _____

Address for Claims: _____

Insurance Company Phone Number: _____

Secondary Insurance

Policy Holder Name: _____ SS# _____

Insurance ID # _____ Group #: _____ DOB: _____

Employer: _____

Dental Insurance Company: _____

Address for Claims: _____

Insurance Company Phone Number: _____

Knowing your personal coverage, benefits, and limitations is a patient's responsibility.

Your estimated out of pocket portion is due at the time of treatment. Any amount due after insurance has paid their portion will be billed and is due within 10 days of billing. Any balances carried by our office over 60 days will be charged interest at a rate of 18% per year (charged monthly). Any amount not paid by insurance within 45 days will become the patient's responsibility.

We reserve the right to charge for failed appointments or appointments not cancelled with a *48 hour notice*. We charge at a rate of *$40.00 per appointment* or *$40.00 per hour* whichever is greater.

By signing below I acknowledge the information I have provided is true and correct. If there are any changes in the above information I understand that it is my responsibility to inform the office immediately. I understand that if I default on my payment an outside collection agency may be used. I understand that I will be responsible for collection fees of 50% of the outstanding balance. I also understand that interest of 2% per month shall be charged on the outstanding balance during the collection period. I further understand that should suit be brought against me I will be responsible for the court costs and attorney fees.

Responsible Party _____ **Date** _____