FINANCIAL AGREEMENT & INSURANCE INFORMATION

DENTISTRY Of Olde Towne

Kenneth D. Kligman, D.D.S.
Chris Rautenstrauch, D.M.D.
Jacob D. Sluder, D.M.D.

Guarantor Information

Person Responsible for Account _____

Relationship to Patient _____

Home Phone _____ Cell Phone _____

Address_____
(If different from patient) Street City State Zip

As a courtesy to our patients we will complete and file insurance forms relative to dental services. Assignment of benefits will be accepted, but payment for any deductible and/or percentages your insurance carrier does not cover for a specific procedure is required on the day of service.

Primary Dental Insurance

Insurance Company _____Phone_____

Insurance Company Address _____

Subscriber_____ Date of Birth _____

Subscriber ID# _____ Group # _____

Group Name/ Employer_____

Please be aware that dental insurance policies and benefits paid are an arrangement between you and your carrier, and you are responsible for any and all charges that your insurance carrier does not cover. If after six weeks your insurance company has not paid benefits, the balance becomes your responsibility.

Payment is expected at the time of your services. If you have dental insurance, we will provide an estimate of your co-payment and collect that portion at the time of your appointment. If an over-payment is made, you will receive a refund once all claims are processed. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also accept Care Credit, a healthcare financing program that offers interest-free payment plans upon approval.

*Missed appointments or appointments cancelled with less than 24-hour notice are subject to a $50 charge.

*A late fee of 1.5% will be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and may be turned over to a collection agency. Fees may apply. Returned check fee is $25.00

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine.

Signature _____ Date _____