

**ATTENTION PATIENTS**



**You Are Responsible For Knowing Your Dental Insurance Benefits**

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is *only an estimate* and the patient is ultimately responsible for any payment not covered by insurance.

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care. 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 on behalf of my dependent(s).

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date

**AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED**

By my signature below, I hereby authorize the practice to disclose my medical information so that the practice may treat me, seek payment from third parties such treatment (e.g. dental insurance), and generally carry on the practice’s health care operations (e.g. qualify for insurance). I also authorize the practice to disclose my medical information to insurers and providers who may treat me, seek payment for treatment, and for the purpose of their health care operations.

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date

**FINANCIAL ARRANGEMENTS**

For your convenience, we offer the following methods of payment. Please check the option in which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

**Payment in full at each appointment**

\_\_\_\_ CASH \_\_\_\_ PERSONAL CHECK \_\_\_\_ American Express \_\_\_\_ Discover  
\_\_\_\_ CREDITCARD \_\_\_\_ VISA \_\_\_\_ MASTERCARD \_\_\_\_ CARE CREDIT \_\_\_\_ Citi Health

CARD# \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**REGARDING MISSED AND CANCELLED APPOINTMENTS**

At Friendly Dental, we strive to deliver our Best services at the most convenient times for our patients. It is for this reason we offer **LATE EVENING & WEEKEND** hours. This is why we will impose a **\$50 “MISSED APPOINTMENT” fee PER HOUR** for regular appt and **\$100 “MISSED SPECIALIST OR SATURDAY APPOINTMENT” fee PER HOUR** on appointments not cancelled and/or rescheduled within a timely manner. We ask that you kindly provide us with at least a **24-HOUR/reg appointment and 48-HOUR/specialist appointment NOTICE OF CANCELLATION.**

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor Date