FINANCIAL AGREEMENT

Dear Patient:

As a courtesy to you, we have agreed to submit the charges for your recent office visit, and/or other services and await payment directly from your insurance carrier. However, all patients are responsible for their deductibles, co-payments and co-insurance. Please advise which method of payment you will be using below:

_____ Payment by Cash
_____ Payment by Credit Card
_____ Citi Health Card
_____ Payment by Check
_____ Payment by Care Credit®

We offer Care Credit® and Citi Health Card because your smile is important to us. It is a convenient, low minimum monthly payment program for your entire family specifically designed to pay for treatment not covered by insurance.

In order for us to submit to your insurance company, we must have a copy of your current insurance card. It is your responsibility to notify us of any change in your insurance information: Should any information change and we are unaware you will be billed directly and responsible to submit the charges to your insurance carrier.

We will bill dental insurance for those patients that have dental coverage, but you are expected to pay the deductible and co-payment on the day of the services. The co-payment is an ESTIMATE provided by this office, it is to be considered as a guideline until the final insurance payment has been received. We can make NO guarantees of the insurance payments, including available remaining benefits. We are not in network with any dental plans, but we do take most insurance towards payment, providing you have a PPO plan.

When we bill a patient's insurance company, the policy of our office is to await payment for ninety (90) days from the date of service. After the ninety (90) day period, if no payment is received from your insurance carrier, we will bill you for the services rendered. If payment is received from your insurance carrier after your remittance is received we will forward a refund to you.

If you should receive the insurance check instead of our office, please send us the original check from your insurance company and any applicable deductible, co-payments and co-insurance, along with a copy of the explanation of benefits. (We MUST have a copy of this explanation of benefits to properly credit your account.)

FINANCIAL AGREEMENT (CONT.)

Our office is a fully approved and accredited user of the VISA/MASTERCARD/DISCOVER Health Care Incentive Program, which will enable you to use your credit card to automatically cover amounts not paid by your insurance company.

Please initial below:

_____ Guarantee your insurance co-payments with your credit card.

Patient Name _____

( ) VISA ( ) MASTERCARD ( ) DISCOVER

ACCOUNT NUMBER: __ __ __ __ - __ __ __ __ - __ __ __ __-__ __ __ __

EXPIRATION DATE: __ __ / __ __ Security Code: _ _ _

I authorize: Drs Russ & Sender to charge my payment card for the balance of fees not paid by my insurance company after ninety (90) days.

_____

Signature of Cardholder / Patient

I authorize the release of any dental records or other information necessary to process my claims. I also authorize payment be made directly to my provider.
_____ Please Initial

In the event your account has to be sent to our attorney for collection, you will be responsible additionally for:

A. Attorney Fees which are 1/3 of balance due.
B. Costs expended by the attorney.
C. Interest.

I HAVE READ AND UNDERSTAND THE ABOVE:

PATIENT'S NAME (PRINT): _____
PATIENT'S SIGNATURE: _____ DATE: _____