

Guarantor and Account Information

Please complete **both** sides if there are two parties responsible for payment

Section A

Primary Guarantor of Account and Primary Insurance

Name (first, m.i., last) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employed by _____ Address _____

City _____ State _____ Zip _____ If insured, enter Soc. Sec. # _____

Dental Insurance Group # _____ In whose name? _____

Plan # _____ Forms to be mailed to: _____

City _____ State _____ Zip _____ Please **circle persons** covered under this plan and write their names:

Self only; _____ spouse, child, step-child; _____ child, step-child; _____ child, step-child;

other (use same format as above) _____

Sign here if you want insurance benefits paid to our office (if you want us to accept assignment):

Payment Policies

Payment is expected when services are rendered unless other arrangements are made in advance.

Payment may be made with cash, personal check, MasterCard, VISA, Discover or American Express.

Two arrangements are available for deferred payment (with approval):

1- Simple billing: A statement will be sent, usually around the 25th of the month. It is due in full by the *next* billing cycle. Any unpaid balance will be subject to a billing charge of \$3 per statement, or a finance charge of 1.39% per month, or 18% expressed as an Annual Percentage Rate (APR), whichever is greater.

2- For complex treatment plans: Payment may be made over 3 months with no interest or billing charge. After 3 billing cycles the balance will be *due in full and subject to finance charges* as explained above.

Insurance: In cases where we have accepted assignment of benefits, you will be billed for your estimated portion. You will have 30 days to pay, after which finance charges will begin as explained above.

Costs of Collection: If we refer the collection of your account to an attorney, you agree to pay our reasonable attorney's fees, court costs or other collection costs as permitted by law.

I have read and understand the terms and policies set forth in the "Payment Policies" as outlined above, and agree to abide by them.

Signed: _____ Date: _____

Section B

Secondary Guarantor of Account and/or Secondary Insurance

Name (first, m.i., last) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employed by _____ Address _____

City _____ State _____ Zip _____ If insured, enter Soc. Sec. # _____

Dental Insurance Group # _____ In whose name? _____

Plan # _____ Forms to be mailed to: _____

City _____ State _____ Zip _____ Please **circle persons** covered under this plan and write their names:

Self only; _____ spouse, child, step-child; _____ child, step-child; _____ child, step-child;

other (use same format as above) _____

Sign here if you want insurance benefits paid to our office (if you want us to accept assignment):
