Prime Dental Design

FINANCIAL INFORMATION FORM

PATIENT INFORMATION

Name _____Male ___ Female _____

Address_____

E-mail Address_____

Date of Birth _____Telephone Number: _____

Employer _____Occupation_____

Social Security # _____Driver's License #_____

Member ID for Dental Insurance _____Group Number_____

POLICYHOLDER (if other than the patient)

Name _____Male ___ Female ___

Relationship to Patient_____Address _____

E-mail Address _____

Date of Birth _____ Telephone # _____

Employer _____Soc. Sec. #_____

Member ID of Dental Insurance (Benefits Number)_____

Driver's License #_____

DENTAL INSURANCE INFORMATION

Insurance Company Name_____

Claims Address _____ P.O. Box _____

Zip Code_____ Company Toll Free Phone # _____

Payer ID #_____

FINANCIAL RESPONSIBILITY

Thank you for choosing Prime Dental Design as your dental care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

PAYMENT: Fees for services are due when treatment is rendered. Payment may be made by debit or credit cards. We also offer financing trough third party financing companies such as Care Credit.

INSURANCE: If you have dental insurance, we will make a good faith estimate of your benefits. We will file the appropriate claim forms with your insurance company, provided you supply us with documented evidence of coverage, with an insurance card. If your insurance provider denies coverage, the amount will then become due and payable by you. Although we will make every effort to help you understand and obtain your benefits, we cannot guarantee your insurance provider will pay. The amount of reimbursement is determined by the insurance carrier. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim.

THIRD PARTY PAYMENT: If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.

NON-PAYMENT: In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

INTEREST: Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance (18% per year) unless prior payment arrangements have been approved.

FINANCIAL RESPONSIBILITY AGREEMENT

I have read the financial responsibility for dental services, agree to the terms and accept full responsibility for all charges for services rendered.

Print name _____

Patient or Authorized Representative Signature_____

Date:_____ Relationship to the patient:_____