

Payment and Insurance Information, Statement of Responsibility

Payment Information

As a condition of treatment by this office, all fees for private accounts are due and must be paid at the time the service is performed. In case of divorce or separated parties, documentation of financial responsibility for the patient must be provided at the time of the visit. (Please see the Statement of Responsibility, below.) Fees for proposed dental services are honored for a period of 60 days from the date of the patient's examination.

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

CASH **CHECK** **VISA** **MasterCard** **DISCOVER**

Expiration Date _____ Credit Card Account # _____ Security Code _____

Cardholder Name: _____

Any other payment arrangement must be authorized by the Office Manager in advance of treatment and may be subject to a service charge of 1.5% per month (18% per year) on the unpaid balance. Account balances equal to or older than 60 days past due will be charged to the credit card you have provided.

Insurance Information

Please provide information about your dental insurance and a copy of each insurance card listed below.

PRIMARY CARRIER

Subscriber Name: _____

Subscriber SS# _____

Group Number: _____

Employer Name: _____

Insurance Name _____

Telephone # _____

How long have you had this insurance? _____

SECONDARY CARRIER

Subscriber Name: _____

Subscriber SS# _____

Group Number: _____

Employer Name: _____

Insurance Name _____

Telephone # _____

How long have you had this insurance? _____

If you would like us to submit insurance forms to your dental insurance carrier on your behalf, please sign below. We are required to keep your signature on file. Treatment plans are never submitted without your approval.

I authorize release of any information relating to this claim.

Signed patient or parent (if minor)

Signed insured person

Statement of Responsibility

In consideration of the professional services to my child, I agree to accept responsibility for the payment of such services. I agree to pay all costs and reasonable attorney fees incurred by my failure to remit payment for these services rendered. I grant my permission to you or your assigned representatives to telephone me at home to discuss matters related to this form. I have read the above conditions of treatment and agree in content.

Signed: _____ Date: _____

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Licensed Specialists in Pediatric Dentistry Serving Infants, Children, Adolescents and Patients with Special Needs Since 1980