ATRIUM DENTAL CARE

FINANCIAL AGREEMENT

Responsible Party: ______________________________ Home Phone: (___) __________

Employer: ______________________________ Work Phone: (___) __________

Spouse's Employer: ______________________________ Work Phone: (___) __________

Please check *all methods* of payment that apply for your dental care.

❑ I DO NOT HAVE DENTAL INSURANCE

❑ I can pay by: ❑ Cash ❑ Check ❑ Bankcard (Visa, MasterCard or Discover), on each visit as treatment progresses.

❑ I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a credit application and that monthly finance charges may be involved.

❑ I HAVE DENTAL INSURANCE

Company Name/ Policy #: ______________________________

❑ I elect to pay my deductible of $ __________, and any portion of the costs my insurance does not pay ***on each visit*** by:
❑ Cash ❑ Check ❑ Bankcard (Visa, MasterCard or Discover)

❑ On extensive treatment, I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a credit application and that monthly finance charges may be involved.

For Office Use Only: Cat. 1 ___% Cat. 2 ___% Cat. 3 ___% Ded. _______ Yearly Maximum __________
Ded. Apply to Preventive ❑ Y ❑ N

I realize that my insurance benefits can only be *estimated* and that no insurance company will pay *all* treatment costs. I understand that *I am responsible for all costs not paid by my insurance company within 45 days of the insurance claim submittals, and that interest accrues on my account after this time.*

Date: ______________ Signed: ______________________________

I consent that the above signature may be kept on file for submittal of any insurance claim forms pertaining to my family's dental treatmen