FINANCIAL AGREEMENT FOR BRIDGELAND DENTAL CARE

We offer two different options in which your dental treatment can be paid. Please choose one of the following options.

Option One- Payment in full at the time of service. We will be happy to submit your dental claim on your behalf and inform your insurance company to issue the payment of any benefits directly to you.

Option Two- Direct billing - Assignment of benefits to Bridgeland Dental Care. This means you are requesting your insurance to issue payment of your dental benefits to the dental office. Assignment of benefits from your insurance company will require a valid **VISA, MASTERCARD OR AMEX** to be left on file. Bridgeland Dental Care will not allow any balances to extend past 45 days from date of service.

All dental procedures in our practice are treatment planned based on the dental needs of the individual patient; not limited to the benefits extended by their insurance providers. Neither the dental office nor its employees will assume the responsibility of knowing individual dental coverage details.

Credit Card Authorization

I authorize Bridgeland Dental Care to keep my signature and card information on file, and to charge my **VISA, MASTERCARD, or AMEX** account for the following ***(please initial next to the following four points);***

_____ Balance of charges not paid by my insurance immediately upon receiving payment from your insurance company.
** *Individual phone calls from the office will **NOT** be made before the card is charged for expenses, unless the amount should **exceed $200.00**. A receipt of payment will be sent to your home.***

_____ All outstanding balances on my family account if not paid within 45 days by my insurance.

_____ Charges accrued as a result of broken appointments or short notice cancellations within reason. This fee is $50.00 per individual for each failed appointment.

_____ This authorization will be held for each client listed below until otherwise notified to our office in writing stating otherwise.

Patient Name(s):_____

PLEASE WRITE DOWN THE NAMES OF ALL FAMILY MEMBERS AUTHORIZED FOR THIS CREDIT CARD

Cardholder Name: _____

Cardholder Address: _____

City: _____ Postal Code: _____

Phone Number: (H)_____ (C)_____

Account Number: _____ Expiry Date: _____

Cardholder Signature:_____

Insurance Authorization

I hereby authorize payment directly to Bridgeland Dental Care, for services rendered, otherwise payable to me. I authorize the releases of any information relating to my dental claims through this office.

Authorized Signature: _____ Date: _____