Santiago Dental Wellness

SEDATION. IMPLANTS. AESTHETICS.

AUTHORIZED CREDIT CARD PAYMENT AND FINANCIAL POLICY

I authorize Santiago Dental Wellness to keep my signature on file and to charge my credit/debit card for:

☐ Balance of charges not paid by insurance within 45 days

☐ All visits this year

I assign my insurance benefits to the provider listed above. We do our very best to provide you the best estimate of how your benefits will help. Because we cannot be absolutely certain of the amount of your benefits, we ask that you help us by leaving the information requested above to take care of your balance. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I understand that I will be notified in advance if charges exceed $100. I will also receive a courtesy call when the card has been charged for less than $100.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

Card # _____ Exp. Date _____ Security Code _____

Cardholder Signature _____

Dental treatment is an investment in your general and dental health. We want to assist you in making the financial arrangements and submitting your insurance claims. Please note that **PAYMENT FOR SERVICES IS DUE AT THE TIME THEY ARE PERFORMED.**

As a courtesy to you , we will bill your insurance company directly. If we do not receive payment from your insurance in 45 days, the balance is then your responsibility and due in full.

We charge $40 for a returned check from your bank. Because we schedule one-on-one time with each patient, we require 48 business hours notice if you are unab le to make your appointment. Failure to do so will result in a $75 charge to your account.

The undersigned patient or responsible party acknowledges that he/she has read and understands the information printed above.

Signature _____ Date _____