AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION OF PAYMENT OF BENEFITS

I hereby authorize AC Dental to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize payment directly to AC Dental. I agree that a photocopy of this authorization is as valid as the original.

Signature_____Date_____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

PAYMENT AGREEMENT

I understand and agree that payment is due at the time services are rendered and that health, dental and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of insurance.

In the event my account balance is referred to any agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

I understand that if I suspend or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees for professional services rendered will be immediately due and payable.

Signature_____Date_____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

RESPONSIBLE PARTY

(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

SSN DOB M or F Sex

Street City State Zip

( ) ( )
Home Phone Work Phone May we contact you by Email? Y N (Please enter email address)

METHOD OF PAYMENT

How will you pay for today's visit? ☐ Cash ☐ Bank Check ☐ *Care Credit ☐ *Unicorn ☐ Charge Card

☐ Other_____ ***See Receptionist for Application Forms**

Charge Card Authorization

By signing hereunder, I hereby authorize AC Dental to bill my charge card account should any balance for services rendered remain outstanding for more than (60) sixty-days. If the account information given expires or is otherwise discontinued, I agree to give AC Dental information as to an alternate charge account, which may be used. My account is as follows:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Card #_____Exp Date_____

Signature_____ Date_____