PATIENT INFORMATION AND HEALTH HISTORY

PATIENT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** □Married □Sngl DOB**\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** SSN#**\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_**

HM# \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we text you: □yes □No WK#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Email is vital to our verification and communication: **Must** **List your E-mail**\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PATIENT’S ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB**\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** SSN#**\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_**

HM# \_\_\_\_\_\_-**\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_**CELL#\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_WK#\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ *e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

EMPLOYED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE (IF ANY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

CHIEF ORAL COMPLAINT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ARE YOU HAPPY WITH YOUR SMILE? □ **☺** Or □ **☹**

DATE OF LAST EXAM \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ ANY PREVIOUS MAJOR DENTAL TREATMENT □ YES □ NO WHEN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING INDICATE WITH A** 🗷

□ Teeth sensitive to cold, heat, sweets, or pressure □ Bad breath □ Cigarettes, pipe or cigar smoking

□ Bleeding gums. How long \_\_\_\_\_\_\_\_\_\_\_\_ □ Unpleasant taste □ Texture of toothbrush \_\_\_\_\_\_\_\_\_\_

□ Food impaction □ Unfavorable dental experience □ Frequency of brushing \_\_\_\_\_\_\_\_\_

□ Clenching or grinding □ Complications from extractions □ Dental flossing per day\_\_\_\_\_\_\_\_\_

□ Swelling or lumps in mouth □ Orthodontic treatment □ Water pick device

□ Frequent blisters on lips or mouth □ Mouth breathing □ Disclosing tablets or solution

□ Pain around ears or unusual □ Fingernail or cheek biting □ Fluoride supplements

clicking sounds while eating

**MEDICAL HISTORY**

PHYSICIAN’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF LAST EXAM\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING INDICATE WITH A** 🗷

□ Allergies to drugs “list below” □ Asthma □ Stroke

□ Allergies to anesthetics □ Hay fever or allergies in general □ Thyroid

□ Heart ailments “list below” □ Diabetes □ Eye disorders

□ High blood pressure □ Kidney problems □ Tuberculosis

□ Neurological problems □ Liver problems or Hepatitis □ Tonsillitis

□ Radiation treatments □ Cancer / Malignancies □ Ulcer or colitis

□ Excessive bleeding from cut or extraction □ Psychiatric care / Emotional problems □ Pregnant if so, month \_\_\_\_\_\_\_\_\_

□ Anemia or Blood problems □ Rheumatic fever □ Venereal disease

□ Arthritis □ Sinus problems □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Immune System Disorders (AIDS, HIV, ARC)

Describe any medical treatment including drugs taken, even though not listed above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMENTS: A maximum of $50.00** per 15 minutes of appointment time will be charged for failed or cancelled appointments without prior notification of 48 hours (appointment are made in a *minimum 1 hour time frame*). Once an appointment is made, please remember this time is reserved for you.

**INSURANCE: All professional services rendered** **are charged directly to the patients and are responsible for payment of fees**. I understand and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I authorize release of any information relating to dental claims. I hereby authorize insurance payments directly to Advanced Dental and Dentures & Associates. **Collections and Refunds:** Accounts sent to collections will be responsible for costs associated with such action. Including but not limited to services fees, collection fees, interest, postage, phone calls, court cost, plus all cost that Advanced Dental and Dentures may incur collecting delinquent accounts. No refunds will be issued for uncompleted or abandoned treatment. All monies paid regarding uncompleted or abandoned treatment will be applied to administration costs and Doctors consultation fees. All prepaid monies for future treatment is nonrefundable and will be treated as uncompleted and or abandoned treatment.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

Financial Policy

Thank you for choosing Advanced Dental and Dentures to provide your dental care. Our staff is committed to providing you with the best, most comfortable care possible. We also want to make clear our policies to ensure you have a great experence.

**Payments and Appointments** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. Full payment is expected at time of service. For insurance, your portion minus estimated insurance is due up front.
2. We know dental treatment can be an unexpected expense and offer several financing options to help meet this unbudgeted expense. We also accept all major credit cards, checks, and cash.
3. There will be a service charge for all returned checks or stop payment checks of $150 plus any costs associated with the returned check or stop payment incurred by Advanced Dental and Dentures & Associates.
4. Any appointment that needs to be cancelled **must be done at least 48 hours in advance**, there will be a maximum fee of $50 per appointment time. Patients late by 15 minutes, that can’t be fit into the schedule will be charged a broken appointment fee.

**Insurance** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. **Insurance is the full responsibility of the patient not Advanced Dental and Dentures**. It is a contract entered into by yourself and the insurance provider. Advanced Dental and Dentures does not enter into dispute with any insurance company over any claim. We will try to provide all the proper forms and paper work needed to pay the claim but will not take responsibility for failure to pay for any reason; even if the insurance company states they did not receive the paperwork. It is the responsibility of the patient to make sure the insurance pays.
2. After your insurance provider has processed your claim (about 30 days) you will receive a statement showing the amount due. **Payment is due 14 days after the insurances pays and will be collected according to the Credit card authorization form on file.**
3. Patients are responsible for all fees over the “Usual, Customary, and Reasonable” posted by their insurance provider. Smile Designs does not hold to the U.C.R set by insurance. U.C.R is different per insurance provider and not a set standard.

**Lab work, Treatment and Radiographs (X-rays)** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. All lab work not completed within 30 days from the start date due to any reason, at no fault of Advanced Dental and Dentures will be considered abandoned treatment. The balance is still due and will be sent to collections. Lab work will not be held past 90 days.
2. All lab work is billed to the patient and insurance when started. This is the medical and ADA standard.
3. **All treatment is billed in full when started**. Any patient not wanting to finish treatment for whatever reason is still responsible for payment in full, not a partial amount. The dentist has finished the work minus cementing the completed restorative work. We still have to pay the lab, shipping, staff, etc., and consider the work abandoned.
4. **Refunds will not be issued for uncompleted or abandoned treatment**. All money paid will be applied to administration, consultation, lab, shipping, staff and doctors chair time fees. All prepaid money for future treatment is nonrefundable and will be treated as a credit that may be transferred to immediate family members.
5. Radiographs by Florida State law must be kept by the dental office and are the property of the dental office not the patient. You are entitled to a copy but will be charged $25 for duplication. If your x-rays are digital and able to be emailed we will email them to another dentist at no charge with authorization from the new treating dentist.

I have read and understand the policies outlined above. I have been given the opportunity to ask questions concerning Advanced Dental and Dentures Financial policy and have had all questions answered to my satisfaction and agree to the policies above. I further agree that any suit, action, or proceeding with respect to this Agreement shall be brought in the courts of Jacksonville “Duval County”, in the State of Florida or in the U.S. District Court for the Middle District Court “Jacksonville Division” of Florida.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Notice of Privacy Practices

This notice describes how medical/dental information may be used and how to obtain access to the information. Please review this privacy form carefully. This practice is required by law to maintain the privacy and confidentiality of your protected health information.

**The following are reasons for which Advanced Dental & Dentures may disclose your Health Care Information.**

**Treatment:** To other health care professionals within our practice for the purpose of treatment, payment or health care operations. (Example) “It may be necessary to seek a consultation regarding your condition from other health care providers associated with this practice.”

**Insurance, Collections, or for Payment by Third Party:** To your insurance provider, collections, or to a third party finance company for the purpose of payment, resolving payment disputes or health care operations.

**Worker’s Compensation:** As necessary to comply with State Workers’ Compensation Laws.

**Emergencies:** To notify or assist in notifying a family member or responsible care taker in the event of an emergency or death.

**Public Health:** As required by law, to public health authorities to: prevent or control disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection control.

**Judicial and Administrative Proceedings:** In administrative or judicial proceeding as required by the court or by subpoena.

**Law Enforcement/Deceased Person:** To law enforcement officials for purposes such as identification and/or to assist coroners or medical examiners complying with a court order or subpoena.

**Public Safety or Research:** To prevent serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies:** For military, national security, government or prisoner benefits purposes.

**Appointment Reminders and Marketing Advanced Dental & Dentures** staff will contact you for marketing purposes or fund-raising purposes, by text, phone, or email: (Example) “As a courtesy, we call, text, and email you prior to your appointment as a reminder. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this message, text or email other than the date and time of your scheduled appointment.”

**Change of Ownership** In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

**You have the right** to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested. **You have the right** to inspect a copy your health information. **You have the right** to request that this practice amend your protected information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. **You have the right** to receive an accounting of disclosures of your protected health information. **You have a right** to a copy of the Notice of Privacy Practices upon request.

**Changes to this Notice of Privacy Practices** This practice reserves the right to amend this Notice of Privacy Practices and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice. If you have questions about any part of this notice please ask or call the office.  **Complaints:** should be directed to **Advanced Dental & Dentures by calling this office**. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: **DHHS**, **Office of Civil Rights** 200 Independence Avenue, S.W.Room 509F HHH Building. Washington, DC. 20201

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes described above in the Privacy Notice. **I give Advanced Dental & Dentures staff authorization to speak with the listed people below** concerning my protected health information. I authorize t Advanced Dental and Dentures & Associates to send messages about appointments or marketing information by email, mail, or my voice mail system.

Initials: \_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: 🞏Spouse 🞏 Relative 🞏Guardian 🞏 Friend

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: 🞏Spouse 🞏 Relative 🞏Guardian 🞏 Friend

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: 🞏Spouse 🞏 Relative 🞏Guardian 🞏 Friend

**This authorization and authorized people shall remain in effect until I advise Advanced Dentistry & Dentures otherwise in writing only.**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Guardian Signing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Credit Card Authorization

In an effort to better serve our patients and simplify your billing experience Advanced Dental & Dentures offers credit card acceptance. Accounts on file can be charged either as a one-time payment on request or as back up payment in the event of a past due balance with the Office. Your card information will be held on a highly encrypted, secure medical grade server, designed to handle extremely private medical data that exceeds all HIPA regulations for such sensitive data.

You are authorizing **Advanced Dental & Dentures** to maintain your card information on file to cover the financial responsibility after insurance. If you choose not to participate all charges will be due in advance and we will help you self-bill your insurance. You may also request a pre-determination from your insurance company before we proceed.

Credit/Debit Information

Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Card Holders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holders Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Check Card Type | **□** Credit | **□** Debit | **□**HSA | **□** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_/\_\_\_\_\_\_ 3 Digit V Code \_\_\_\_\_\_\_\_\_\_

Choose Billing Option

**\_\_\_\_\_\_\_\_\_\_ (initial Option 1)** I authorize **Advanced Dental & Dentures** to charge any account balance in full after the insurance has paid its portion to the card on file.

**\_\_\_\_\_\_\_\_\_\_ (initial Option 2)** I choose to manually pay any account balance after insurance. Charges not covered by insurance are due 14 days after the insurance pays its portion. After 14 days if the account is past due it will be charged a late fee of $25 and account balances will automatically be charged to the card on file after 21 days past due.

Personal Guarantee and Authorization

I authorize **Advanced Dental & Dentures** to charge my credit card in agreement with the billing option I selected above. I guarantee the performance of the finical provision of this agreement. After payment by credit card, you agree not to cancel, revoke or charge back the contracted and authorized charge on your credit card by **Advanced Dental & Dentures**. If you do so, and it is later determined that the charge was properly authorized, you agree to pay all out of pocket fees and costs incurred by **Advanced Dental & Dentures** as a result of the improper cancellation, revocation, charge back, or dispute. I also agree that insurance is a contract between myself and the insurance and not **Advanced Dental & Dentures** and the insurance. We bill insurance as a courtesy to you but do not enter into dispute as to lack of payment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_