**Wayne Silverstein D.M.D**

**Implant, esthetic & general dentistry**

**Ph: 212-319-7200**

[info@madisonsmile.net](mailto:info@madisonsmile.net)

Our Financial Policy

Payment for all services rendered is due the day of service. As a courtesy we also offer a financial arrangement whereby we are happy to submit your charges to your dental insurance and wait for payment from them. However, if you choose this option we require your copayment on the day of service. We request you leave a credit card number for any unpaid balance your insurance doesn’t pay and any unpaid balance will be charged to your credit card. If you would prefer us to notify you before the charge is submitted please indicate on the bottom of this page. In order for us to serve you better we have implemented a cancellation and broken appointment policy. If you break or cancel you will be charged a fee.

Please keep in mind that your dental insurance is your benefit. Our estimates are given as carefully as possible. However, your insurance carrier will ultimately decide on the benefit to be released.

I authorize Wayne Silverstein to keep my signature on file and to charge my credit card for the balance of charges not paid by insurance with 90 days and not to exceed the cost of treatment.

Patient/ Cardholder Name Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notify prior to charge? YES \_\_\_**\_ NO** \_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

**Subscriber Information Patient Information**

Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Email :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Company’s Name :\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company :\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Subscriber** Self Spouse Dependent Child Others