DENTAL ASSOCIATES OF ARLINGTON HEIGHTS

FINANCIAL POLICY
RESTORATIVE AND HYGIENE APPOINTMENTS

All patients are required to make appropriate payments at the time of service. In order to serve you better, we will assist in applying the selected payment option for each of your visits to our office.

1) **Pay in full on date of service and all insurance benefits will be assigned to patient.**

2) **Pay applicable co-payments at time of service. Must sign our "Consent to Pay" and balance due will be charged to credit card* once insurance benefits are received and applied to patient account.**

**Patient will receive a statement reflecting any amounts charged to credit card. Any amounts declined by a credit card company will immediately be billed to the patient and due upon receipt of statement.*

I understand the financial arrangements above and agree to comply with them as stated and that I am responsible for ALL fees, regardless of insurance coverage.

Please select one: OPTION 1 ☐ OPTION 2 ☐

_____ _____
Signature Date

CONSENT TO PAY

I authorize **Dental Associates of Arlington Heights** to keep my signature on file and to charge my Visa, MasterCard or Discover account for balance of charges not paid by insurance within 30 days.

I authorize assignment of my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to the health care provider. Account number and expiration date may be updated as needed.

Patient/Cardholder Name _____

Billing Address _____ Zip _____

Account Number_____

Exp. Date_____ Sec. Code_____

Cardholder Signature _____Date_____