FINANCIAL OPTION

I ______________ choose the following method of payment for my dental care and the care of my dependents.

* I will be paying with....
*Cash___, Check___ , MasterCard___, Visa___, Discover___, Care Credit___, or other.

**Card Number: __________________________, Exp date: ______

* I have dental insurance through _____________________. _______

* I elect to pay my deductible of $______ and any un-insured portions as treatment progress.

*Please note there will be a $75 broken appointment fee without a 24 hour notice.
* Financial Responsibility: We want our patients to know that all professional services are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms to assist in obtaining your benefits. We do not render our services on the basis that insurance companies will pay our fees. The patient is also responsible for any court cost and/or attorney fees that should the account be placed for outside collection, at that time a 33% fee will be added to the remaining balance of each individual account. I sign below that I understand this agreement.

Signature: ______________________________Date:_______

Insurance Policy

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates the processing of your insurance claim. If you have any questions feel free to ask us. Thank you.
* I understand and agree that I am responsible for the payment of all my treatment fees on my account. If my insurance company fails to make payment within 60 days, I will be responsible for the full amount owed to Dr. Brewer.
* I understand and agree that I am responsible for the estimated amount not paid by the insurance at time of treatment.
* I understand that after the insurance company pays Dr. Brewer there could still be a remaining balance, for which I am responsible in full at that time.
* I understand and agree that I am responsible for notifying Dr. Brewer's office of any changes in my insurance status. Also, I am responsible for bringing a completed claim form to be kept on file with your office.

***Please know we never know what your insurance company will pay regardless what they tell you or us.**

***Your scheduled appointment time has been reserved specifically for you. We request 24-hours notice if you need to cancel your appointment. We are aware that unforeseen events sometimes require missing an appointment. After missing your 2nd appointment without notifying us 24-hours in advance, you are subject to being charged an additional fee.**

*Signature on file:

We request for your convenience a signature on file for either of the following credit cards; Visa, MasterCard, Discover, American Express and Care Credit. This will allow for us to keep billing to a minimum and better serve your needs by billing the exact difference of the balance of your charges to the credit card.

Signature on File: ______________________________ (Patient)
Responsible Party: ______________________________ (Minor)