FINANCIAL AGREEMENT

We will gladly accept the following payment options:

1. **Cash or check.** We are happy to offer a 5% pre-payment courtesy discount for all treatment paid in full by cash or check on the day treatment is rendered.
2. **Credit card.** Our office accepts Visa, MasterCard, American Express and Discover.

Because the insurance policy is an agreement between you and insurance company, the ultimate responsibility for all charges lies with you. If after 45 days the insurance company has not paid on the claim, you will be responsible for the total or remaining balance which will be applied to your credit card.

Collection

In the event the balance becomes more than 45 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed, including reasonable attorney fees and court costs. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

CONSENT TO PAY

I authorize Dental Associates of Arlington Heights to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover account for balance of charges not paid by insurance company within 60 days.

____

PATIENT/CARDHOLDER NAME

____

BILLING ADDRESS

______________________ ______________

CITY ZIP CODE

CREDIT CARD #______________________

EXP. DATE _______ / _______ SEC CODE ____________

______________________ ______________

CARDHOLDER'S SIGNATURE DATE

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