

\PAYMENT POLICIES

It is important to understand that whether or not you have insurance, the fee for any service provided is your responsibility. If you have dental insurance, we will help you estimate your benefits. There are many factors that can impact your estimate. These include, but are not limited to, services performed at another office, treatment plan changes, benefit exhaustion, insurance fee schedules, or plan termination.

Payment is due at each visit with the total estimated remaining balance due by completion of treatment. Any balance remaining after insurance processing, whether denied, partially paid, or changed in any way, is the full responsibility of the patient/parent.

My signature below certifies that I understand and agree to pay Frederick J. Norfolk, DMD the total amount due for any and all services rendered .

Signature _____ Date _____

INSURANCE

Dental Insurance Yes No (if yes, please complete below.) **If there is more than one insurance, please ask for an addt'l form**

Subscriber Information

Name: _____ Social Sec.Number: _____ DOB: _____

Address: _____ Town/City: _____ State: _____ Zip: _____

Home Phone Number: _____ Business Phone Number: _____

Place of Employment: _____

Name of Dental Insurance Carrier: _____

Insurance Billing Address P.O. Box # or Street: _____

Town/City: _____ State: _____ Zip: _____ Phone #: _____

ID#: _____ GROUP NUMBER: _____

Patient/Parent Signature for Assignment of Benefits: _____

(Your signature here authorizes your insurance company to send payments directly to the provider of dental services. If this line is unsigned, your insurance benefits would be sent directly to you and payment of dental services would be due at the time of service.)

Patient's Release and Confirmation Signature: _____

(Your signature here authorizes your dentist to copy or give dental related radiographs or information to your insurance company.)

CONSENT TO TREATMENT

I consent to the performance of dental services deemed necessary or advisable. Further, I certify that the information provided on this form is accurate and correct to the best of my knowledge.

Signature of Patient/Parent _____ Date: _____

Doctor Signature: _____ Date: _____