INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Lee
Name of insurance company(ies)
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end with my current treatment plan in completed or one year from the date signed below.

_____ _____
Signature of patient, parent, guardian or personal representative Date

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. As a condition of your treatment by this office, financial arrangements must be made in advance. The estimated patient portion payment is due at the times of service, unless other arrangements have been made. I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. If you have dental insurance, we will be glad to assist you in filing claims. However, you must realize your insurance is a contract between you, your employer, and the insurance company. Dr. Lee is not a party to that contract. If your insurance does not pay within 90 days, we will require you pay your bill in full and wait for reimbursement from your insurance company. I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. In the event my account goes unpaid, I understand that there will be a finance charge of 1.5%. I understand I will be held responsible for the cost of collecting my unpaid account, including, but not limited to, court costs, attorney fees and collection fees. There is a $40.00 service fee for returned checks.

I give my permission for you to telephone me at home or at my work to discuss matters related to this form _____
Initial
I have read and understand the above financial arrangement and insurance procession policy.

_____ _____
Signature of patient, parent, guardian or personal representative Date

CANCELLATION & NO SHOW POLICY

I understand Dr. Lee values my time and will make it a priority for me to be seen in a timely manner. However, if I am unable to keep my scheduled appointment I will contact the office at least 48 hours prior to my appointment. If I am unable to provide 48 hours notice I understand 2nd & Vine Dental reserves the right to charge $50.00 per hour for the total scheduled missed appointment time.

_____ _____
Signature of patient, parent, guardian or personal representative Date

I certify that the information provided on this form to be true and correct, to the best of my knowledge.

_____ _____
Signature of patient, parent, guardian or personal representative Date

_____ _____
Please print name of patient, parent, guardian or personal representative Date