Payment, Financial and Insurance Information

☐ *ID Checked*

Today's Date: _____
Patient's Name: _____
Parent/Guardian (if under 18): _____ Relation: _____

We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatment, and payment expectations. In addition, we are also dedicated to making quality care as cost-effective as possible. To assist you with your care we provide the following payment options:

Payment Options

We ask that all payments or co-payments be made at the time of service. For your convenience the following forms of payment are accepted:

1. Cash, Checks, money orders
2. Major Credit Cards and Debit cards
3. *CareCredit* – A no interest financing plan we offer as a separate line of credit to cover you and your family members' dental healthcare needs. CareCredit allows flexible and convenient low monthly payments and spreads them out over time. Please ask for more information if you are interested in financing options.

Insurance: Our office is happy to help you process your insurance. We will complete our portion of the claim form and send it promptly at no charge. To avoid confusion, it should be understood that insurance billing is an elective service provided to our patients. Difficulty obtaining insurance payment may occur, and **insurance payments cannot be guaranteed**. The patient is solely and ultimately responsible for payment.Please feel free to discuss any questions with us at any time.

I have read and understand the above information _____ (please initial).

PRIMARY DENTAL INSURANCE

Subscriber: _____
Subscriber's Date of Birth: _____
Subscriber's SSN: _____
Relationship to Patient: _____
Insurance Co: _____
Ins. Address: _____
_____
Phone # _____
Group #: _____ ID#: _____
Employer: _____
Electronic #: _____
Family members covered: _____

SECONDARY DENTAL INSURANCE

Are you covered by additional insurance? ☐ Yes ☐No

Subscriber: _____
Subscriber's Date of Birth: _____
Subscriber's SSN: _____
Relationship to Patient: _____
Insurance Co: _____
Ins. Address: _____
_____
Phone # _____
Group #: _____ ID#: _____
Employer: _____
Electronic #: _____
Family members covered: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Dr. Robert L. Brookings all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date