Payment Options & Agreement

I, _____agree to pay for the recommended dental treatment as follows:

☐ Assignment of insurance payments (requested by the patient)
Credit Card on file for any unpaid balances by the insurance

Name on card _____
Visa or Mastercard # _____
Expiry Date: Month _____ Year _____ 3-Digit Security Code: _ _ _

Signature of cardholder: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dawson Dental all insurance payments, 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 hereby authorize the doctor to release all information necessary to consider insurance payments for services rendered. I authorize the use of this signature on all insurance submissions.

Date _____ Patient Signature _____

Witness _____

☐ Financing (Pay Bright)

Financing For: _____
Total $: _____
Date _____

☐ Financing (3 month - In house)

Financing for: _____
Name on the card _____
Visa or Mastercard # _____
Expiry Date: Month _____ Year _____ 3-Digit Security Code: _ _ _
Date _____ Patient Signature _____

Witness _____

☐ 3rd Party Payment

Party's name on card: _____ Relationship: _____
Treatment: _____ Total $: _____
Visa or Mastercard # _____
Expiry Date: Month _____ Year _____ 3-Digit Security Code: _ _ _

I understand that I am personally responsible for paying all services in full.