Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Phone Number:_____ Phone Number:_____

Insured ID#:_____ Insured ID#:_____

Group #:_____ Group #:_____

Policy Holder Name:_____ Policy Holder Name:_____

DOB:_____ Relationship:_____ DOB:_____ Relationship:_____

Policy Holder SSN:_____ Policy Holder SSN:_____

Employer Name:_____ Employer Name:_____

Please provide our office with a copy of an up to date insurance card or proof of insurance.

Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

Payment is due at the time services are rendered, unless other arrangements have been made in advance. For your convenience, we accept cash, personal check, Visa, Master Card, Discover, and Care Credit.

Today, dental plans are meant to assist you with your dental needs. These plans are ***not*** intended to cover the entire dental expense. **All co-payments and/or deductibles are to be paid at the time of treatment.** Please remember, you are fully responsible for all charges you incur, regardless of your dental coverage. As a professional courtesy to our patients, we file all insurance claims for you, however, the ultimate responsibility for payment is yours.

Balances older than 30 days are subject to finance charges at the rate of 2% per month (24% annually). There is a charge of $25 for any checks returned by the bank. This disclosure is in compliance with Truth-In-Lending act. Any outstanding balances that exceed 120 days, will be submitted to a collection agency. Please be advised, if your account with us is sent to collections, 25% will be added to your balance.

We certainly understand that scheduling conflicts do occur. We respectfully ask that you give us 24 hour notice if you are unable to make your appointment. Please be advised, multiple cancellations and/or no-shows, may result in a $30.00 cancellation fee.

I hereby understand the office financial policy, and authorize payment directly to Steven C. Stacey, DDS, PC of the dental benefits otherwise payable to me.

_____ _____ _____

Patient Name Signature Date