DOMAN
DENTAL CARE

# Office Financial Guidelines

We thank you for choosing us as your dental care provider. Upon signing this form, you are agreeing to our office financial guidelines.

Payment is due in full at time of service including any copays and deductibles. Your insurance coverage is an agreement between you and your insurance carrier. We will submit claims to your insurance company but we ask that all estimated deductibles and copayments are paid in full at time of service. We accept cash, personal checks, Visa, MasterCard, Discover and American Express for your convenience. We also offer Care Credit, please ask for more details on this service if interested.

I authorize Doman Dental Care to release information acquired in the course of my dental treatment to my insurance company. I authorize benefits to be paid directly to Doman Dental Care. I understand that I am responsible for any unpaid balances. I understand that treatment can not be completed until it is paid for. I understand that I am responsible for all charges associated with this account.

Responsible Party Signature

_____ Date _____