Philip N. Heinecke, DDS, PA

FINANCIAL OPTIONS

PATIENT'S NAME (PLEASE PRINT) ____

METHODS OF PAYMENT (PAYMENT IS DUE AT TIME OF SERVICE)

1. Cash, Check, or Credit Card (MasterCard, Visa, and Discover)
2. Dental insurance (described below)

DENTAL INSURANCE

1. We are pleased you have dental insurance, and our office will assist you in obligating the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company, accurate insurance coverage information is required at the time of your appointment, or payment in full will be required.
2. As a curtesy to you, we will file your insurance and accept assignment of benefits. We will determine, to the best of our ability, what your deductible and co-payment will be. **We ask that you pay this amount at the time of service.** there may be a balance due after the final insurance payment that you are responsible to pay.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If in the case your insurance company does not pay for any specific procedure, you are responsible for payment.

RELATED INFORMATION

1. Returned checks and balances older than 90 days may be subjected to additional collection fees.
2. In the event that the account is not paid and we refer the account to collections, you will be responsible for all the fees incurred for collection of your bill (i.e., attorney, court costs, and collection agency fees)

AUTHORIZATIONS/ACKNOWLEDGEMENTS

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. To the extent permitted by law, I consent to use and discloser of my protected heath information to carry out payment activities.

X PATIENT SIGNATURE ___________________________________ **DATE** _____________________

I hereby authorize and direct payment of any dental insurance benefits to Philip N. Heinecke, DDs, PA

X PATIENT SIGNATURE ___________________________________ **DATE** _____________________

I acknowledge that I have received a copy of Philip N. Heinecke, DDS, PA, notice of HIPPA privacy policy.

X PATIENT SIGNATURE ___________________________________ **DATE** _____________________